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The evidence base for therapeutic group care

A systematic scoping review

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It should be noted that reading about and engaging with material that explores the issue of self harm and suicidality may lead to experiences of distress. This should be acknowledged and support sought if required.

The Centre for Excellence in Therapeutic Care is a partnership between the Australian Childhood Foundation and Southern Cross University. The Centre integrates up to date research evidence with cultural knowledge, practice wisdom and the voices of young people in care to produce reports, practice resources and training to support the provision of high quality, evidence informed therapeutic care.

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Preface

The NSW Government has undertaken major reforms over the past two years aimed at improving outcomes for children and young people in out-of-home care. Following a review by Verso Consulting of its residential care services (2016), it has implemented a new system of Intensive Therapeutic Care (ITC) for young people with high and complex needs. The ITC system delivers a range of intensive therapeutic care options for children and young people including assessment units, therapeutic rostered care homes, therapeutic sibling placements, therapeutic supported independent living programs, and therapeutic homebased care.

To support the effective roll out of the ITC system, Family and Community Services NSW have funded the establishment of a Centre for Excellence in Therapeutic Care (CETC). The CETC is run by the Australian Childhood Foundation in partnership with Southern Cross University.

This report is the first of a series that aims to describe the current state of knowledge in relation to key elements of the ITC system. This report has as its major focus a review of the literature about therapeutic care for children and young people in small congregate care environments. This is the starting point for future research and knowledge generation.

The contents and findings will be disseminated to those working in the ITC system as the basis for strengthening practice in the care and case management of young people accepted into it.

Executive Summary

Background

Internationally, approaches to therapeutic care have evolved over at least fifty years and have varied widely in context, setting and theoretical foundations (James, 2011). Historically, many group care programs throughout the USA and United Kingdom, for example, were offered in large congregate care 'communities', using token economy methods of reward to incentivise young people to behave appropriately (Hobbs, 1966). These models of care were based on theories of behaviour modification, with a focus on the socially unacceptable and challenging behaviours as the locus of concern and treatment. Western European approaches, however, promoted social learning theory as a key determinant of assessment and intervention, based on a holistic view of the child or young person's development (Macdonald & Millen, 2012). More recently, the 'trauma-informed movement' has led to a paradigm shift in approaches to practice with and the care of children and young people who, whilst they may present with challenging behaviours, are viewed as having experienced complex trauma (Bath, 2015).

The emergence of 'therapeutic care' as a form of out-of-home care (OOHC) in Australia, based on an understanding of complex trauma, is a relatively new development. In this country, models of care have traditionally been offered to provide care, containment and support, whilst the therapeutic needs of children were seen as the domain of specialist mental health clinicians providing therapy in a clinical setting (Morton, Clark & Pead, 1999). As recently as the 1990s Australian states and territories began to recognise that 'care was not enough' to meet the needs of children and young people who had experienced complex trauma. In Victoria, for example, it was found that:

> ***…There are a number of children and adolescents in care, who have suffered traumatic early environments, for whom care is not enough to effectively address the aftermath. It is argued that these young people need consistent and high-quality care, which offers continuity of positive relationships. However, they also need systematic therapeutic interventions, to assist them to rebuild their lives and address post-traumatic states and developmental disturbance associated with the severe abuse and neglect they have suffered*** (Morton, Clark & Pead, 1999, p. 5)***…***

These findings paved the way, in that state, for a more integrated, therapeutic response by those who work directly with children and young people outside the traditional one-hour weekly therapy appointment, in the 'other 23 hours' (Bath, 2015; Trieschman, Whittaker & Brendtro, 1969).

Literature Review

Aims and Methodology

This report presents a systematic scoping literature review which aimed to examine and understand the nature and scope of existing research on therapeutic group care across international and English-speaking jurisdictions. It also aimed to scope children and young people's experiences of trauma, and the implications for a therapeutic response. The review methodology was informed by the methodological approach established by Arksey and O'Malley (2005), and more recently applied by Daudt, van Mossel and Scott (2013). Undertaking a systematic scoping review ensures a comprehensive perspective of what has already been studied, and facilitates the identification of research gaps and future research, policy and practice implications. Following an initial scan of the literature, four separate fields of inquiry were confirmed. The overarching research question for this review was:

What is the evidence base for therapeutic care?

In order to comprehensively address this question, four sub-questions or domains were identified as follows:

1. What are the backgrounds of children and young people in group care? What are the implications of their backgrounds for their care needs?
2. What are the needs of Aboriginal and Torres Strait Islander children and young people in care?
3. What are the needs of children of diverse backgrounds?
4. What is known about effective 'therapeutic' models of residential or group care?

Searches were conducted on the four domain areas via eight selected databases, all of which initially returned expansive (n = 2,784) results. A second phase search identified grey literature which included reports available from government websites. A systematic application of exclusion criteria reduced the number of relevant documents to a total of 212. Data were then coded and mapped, and a qualitative synthesis of each domain was undertaken.

Limitations of the review

As is typically the case, there were several methodological limitations. It is likely that there are approaches to therapeutic care that this review has not identified. It is not suggested that these approaches do not have merit, but that it may be that there are no peer-reviewed publications reporting on the approach, or that the search strategy employed did not identify those publications. A second limitation was that only publications in English were analysed. This may have excluded programs of interest that had been published in languages other than English.

Findings and Discussion

Key findings in relation to each of the four domains investigated are summarised below. Given the focus on the overall research question, particular attention is paid to the evidence base for the fourth domain, which investigates approaches to therapeutic care.

1. What are the needs of children and young people in group care?

The conceptualising of children and young people in care as having experienced complex trauma is supported by decades of international research and clinical observation (Gaskill & Perry, 2012; Perry, 2009; Van Horn, 2011).

CHILDHOOD TRAUMA IS TYPICALLY CHARACTERISED BY TWO PRINCIPAL CRITERIA:

- **The EXPERIENCE, which includes the type and duration of trauma experienced, and**
- **The child's REACTION to trauma exposure, such that these experiences overwhelm a child's ability to cope, and cause the child to feel extreme fear, helplessness or horror**

(American Psychological Association, 2008).

Traumatic experiences – sometimes classified as simple or complex trauma (Australian Childhood Foundation, 2010) – are events that threaten the physical integrity of the child or others close to them with harm, injury or death (American Psychological Association, 2008).

Simple trauma typically refers to discrete, life-threatening events such as accidents, or natural or man-made disasters. Experiences may include illness or disease, car accidents, bushfires, floods, industrial accidents, war or terrorism.

Complex trauma involves repeated or ongoing threats of violation or violence between a child and another person. It may include experiences such as bullying; emotional, physical or sexual abuse; child maltreatment or neglect; or witnessing domestic violence. Complex trauma that disrupts the development of secure attachment to a parent or primary caregiver has the potential to have profound developmental consequences for a child (De Bellis, 2001), and is the most stressful trauma that a child can experience (Van Horn, 2011). Complex trauma can occur through the loss or death of a parent (Gregorowski & Seedat, 2013), or when the parent or caregiver is the primary perpetrator of trauma.

Van der Kolk (2003) posited that complex trauma creates an 'assault' on the child's development over time. Not only do traumatised children develop a range of unhealthy coping strategies which they believe will help them survive, they also do not develop the essential daily living skills that children need, such as being able to manage impulses, solve problems and use executive functioning.

Early trauma and stress can have a lasting effect on development, triggering delays in social competence (Becker-Weidman, 2009), development of dysfunctional coping behaviours, and significantly altering a child's brain chemistry; particularly when the adverse condition is chronic and there is a lack of nurturing support (Becker-Weidman, 2009).

COMPLEX TRAUMA IS AN UMBRELLA TERM FOR THESE SEVEN AREAS OF IMPACT:

- **Sensory Development**
- **Dissociation**
- **Attachment Development**
- **Emotional Regulation**
- **Behavioural Regulation**
- **Cognition**
- **Self-Concept and Identity Development (Cook et al 2005).**

As well as these developmental difficulties, the child or young person can also experience discrete mental health difficulties, often connected to episodes of anxiety, depression and specific traumatic symptoms (e.g., flashbacks, intrusive thoughts, nightmares). So, often these symptoms are understood and treated as isolated 'anxiety' or 'depression'; however, for chronically traumatised children and young people this does not tend to be an effective way to address their difficulties. Seeing mental health symptoms as part of an overall picture of developmental trauma is the key (Spinazzola, van der Kolk & Ford, 2018).

Based on this developing body of knowledge, optimal care would respond to trauma by providing a consistently therapeutic environment. The traumas that were experienced in a relationship can be treated in and through the use of a trusting, reparative relationship (Spinazolla et al., 2018; Mitchell, Tucci & MacNamara, In Press). Thus, a focus of the establishment of therapeutic care programs is the centrality of relationships as a vehicle for healing. The three components of the therapeutic milieu – enabling trust based relational intervention – are said to be empowerment, connection and correction (Cook, et al 2005).

In Australia, Bath proposed 'The Three Pillars' as an orientation to healing from complex trauma (Bath, 2015). Challenging traditional mental health treatment paradigms, Bath suggests that *'Healing starts with creating an atmosphere of safety: formal therapy is unlikely to be successful unless this critical element is in place'* (Bath, 2015, p. 6). The 'Three Pillars' for developing and maintaining an environment that facilitates healing are safety, connections and coping (Bath, 2015).

'Ten essential elements' of evidence-informed therapeutic practice in residential care have been identified, also in an Australian context (Verso Consulting, 2016). These ten essential elements are said to apply across a range of 'models' of therapeutic care and have recently formed the basis of a therapeutic care system in New South Wales, Australia. The essential elements, in summary, include: the appointment of a Therapeutic Specialist role, along with well-trained staff who are consistently rostered, reflective practice which includes regular care team meetings, young people who are proactively engaged in an environment where there is an appropriate client mix, a welcoming, homely physical environment, considered exit planning and support, wider organisational commitment and congruence, sound governance and continuous practice improvement (Verso Consulting, 2016, p. 5).

2. What are the needs of Aboriginal and Torres Strait Islander children and young people in care?

The most recent national data suggests that, overall, Aboriginal and Torres Strait Islander children (13.6 per 1,000) were 10 times as likely as non-Aboriginal and Torres Strait Islander children to be admitted to out-of-home care during 2016–17 (AIHW, 2018). Historical and political context is of critical importance in Australia. Numerous studies have highlighted that the violent, colonial history and the intergenerational trauma evident in Aboriginal and Torres Strait Islander communities has had profound impact on their families and relationships (Atkinson, 2013; Bamblett & Lewis, 2007; Bamblett, Long, Frederico & Salamone, 2014; Human Rights and Equal Opportunity Commission, 1997; Lewis, 2018). Professor Judy Atkinson (2013) has argued that traumatic historical events continue to influence life experiences of Aboriginal families and children.

The importance of culturally appropriate/safe interventions

The lack of respect for our culture and our knowledge is a major contributing factor to the over-representation of our children and young people in the child protection system. (Secretariat National Aboriginal and Islander Child Care (SNAICC, 2015).

The rationale for developing culturally appropriate, culturally safe, and culturally informed interventions when working with children and young people from Aboriginal and Torres Strait Islander backgrounds is documented widely throughout literature and policy guidelines and frameworks aiming to address the issues of over-representation of Aboriginal and Torres Strait Islander children in care. The UN Convention on the Rights of the Child (1989) clearly states that an Aboriginal and Torres Strait Islander child *'shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language'* (p. 9).

Bamblett et al. (2014) emphasise the importance of culture by arguing that a cultural identity should not just be an add-on to the best interests of the child in care. Culturally informed practice is that which

> ***…completely understands [that]…denying cultural identity is detrimental to their attachment needs, their emotional development, their education and their health. Therapeutic residential care for Aboriginal children and young people must incorporate cultural knowledges and understandings of their holistic needs…***

Outlined in the body of this report are promising policies, programs and practice frameworks which seek to build cultural identity and promote culturally acceptable ways of healing trauma.

3. What are the needs of children of diverse backgrounds?

Children of diverse and/or minoritised backgrounds such as those with disabilities, those who are queer, those from immigrant or refugee backgrounds, unaccompanied minors and those from culturally and linguistically diverse (CALD) backgrounds have extra challenges in care. Although the scope of literature in this area is limited, evidence suggests, that children and young people's experiences are complicated by other compounding intersections such as race, gender, disability, ethnicity, religion, immigrant status, sexual orientation and class (Dean, 2012; Lavergne, Dufour, Trocmé & Larrivée, 2008).

For example, children and young people from CALD backgrounds often experience unique challenges such as feeling a sense of displacement from their culture as well as discrimination while in care. Similarly, a proportion of LGBTQ+ youth who are placed in care experience more significant and complex challenges compared to their heterosexual counterparts (Hafford-Letchfield, Simpson, Willis & Almack, 2018). Cook and Cohen (2018, p. 3) say that *'LGBTQ youth who are youth of colour, undocumented immigrants, from low income families, living with disabilities, or at the intersection of many or all of these identities, inequities and discrimination in society and in care are… disproportionately represented in out-of-home care systems.'* Some literature has shown that experiences of residential care, in and of itself, produce negative outcomes (see for example, Carr, Duff & Craddock, 2018; Knorth, Harder, Zandberg & Kendrick, 2008). This is more so for children and young people who are from backgrounds that are minoritised and marginalised.

4. What is known about effective 'therapeutic' models of residential or group care?

Twenty-two distinct therapeutic group care approaches were identified by this review that met the criteria for inclusion. An overview of each approach is available in the body of the report. Each of the 22 approaches were initially mapped in terms of the overall model or framework, their implicit or explicit theory of change, and their evaluation or research outcomes. A striking finding was that when assessed against traditional hierarchies of effectiveness in terms of available 'evidence', the majority of the approaches would not rate as promising.

Instead, drawing upon the field of contemporary implementation science an examination of the documented process for implementation of the approaches was undertaken. Informed by the crisis of ongoing over-representation of Aboriginal and Torres Strait Islander children in care, and First Nations children throughout the world, documentation was examined in relation to the extent to which the integration of cultural knowledge in the program design, including efforts to promote and strengthen cultural identity was present. **Culture was defined as the integrated pattern of human behaviour that includes thoughts, behaviours, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, or social group (SNAICC, 2015).**

In summary, our analysis of the approaches drew upon a holistic approach to knowledge. The following criteria were used to determine which of the approaches to therapeutic care could be assessed to be 'promising':

- **Documentation showing broad alignment with five evidence-informed implementation concepts (Atkins & Frederico, 2017),**
- **Documented promising evaluation outcomes, and**
- **Program development is inclusive of cultural knowledge and cultural considerations.**

Based on available, published information, 13 approaches were found by this review to be promising. In 11 of the 13 there was some evidence of positive evaluation or research outcome, as well as indications of alignment with the five key implementation concepts identified earlier (Atkins & Frederico, 2017). Two of these approaches also incorporate cultural considerations (Ardvidson et al., 2011; Lee & Perales, 2005). In the remaining two examples a culturally specific model of therapeutic care was documented as having constructive alignment to the implementation concepts and careful consideration of cultural approaches to healing (Bamblett et al., 2014; Downey, Jago & Poppi, 2015).

Each of the 13 'promising approaches' are summarised below:

1. **Bunjil Burri: An Aboriginal and Torres Strait Islander Australian Model of Therapeutic Care.** Whilst this review did not identify published evaluation outcomes in relation to this model, it did note considered models of planning and consultation with the local Aboriginal and Torres Strait Islander community, with a view to developing a culturally specific model of therapeutic care. The core components of the approach are documented and integrated knowledge that the essence of healing for Aboriginal and Torres Strait Islander children is founded on cultural safety and comprehensive, culturally informed assessments and planning. All frontline staff and managers are described as being committed to and trained in culturally safe, trauma-informed practice (Bamblett et al., 2014).

2. **The CARE** approach involves all levels within the organisation, drawing on trauma and attachment theory with a clearly articulated theory of change. Planning and implementation are well documented and transparent. Leadership commitment is required and supported, and reflective practice valued. Multi-site studies have been completed and have involved non-randomised control groups. Findings in studies located in the USA indicated significant declines for three types of problem behaviour (Holden & Izzo, 2016).

3. **The Sanctuary Model** is a whole-of-organisation approach with a commitment to democratic behaviour required by all staff and managers. Opportunities for and an expectation of reflective practice are built in to the approach as is a clear rationale and theoretical base, as opposed an identified theory change. Most studies identified were conducted in the USA and were of mixed-method design, with results demonstrating a reduction in the use of restraint and seclusion practices, along with positive progress made by young people in problem solving and resolving conflict (Rivard et al., 2004).

4. **The Attachment, Self-Regulation and Competency (ARC)** approach has a clear attachment-focused theoretical basis and extensive program documentation outlining targets for treatment. It seeks to closely 'fit' the individual child's needs and includes a focus on the child's family and community. The authors suggest that 'culture is a critical consideration' (Ardvidson et al., 2011, p. 39) and describe an ethno-culturally diverse cohort of children and proactive efforts to incorporate culturally relevant symbols, metaphors and activities into treatment. One small-scale study showed promising results in terms of permanency outcomes post treatment (Ardvidson et al., 2011).

5. **Building Communities of Care (BCC)** is an approach that is holistic and ecological in design with a clear theoretical foundation. Consistency of the therapeutic experience across multiple domains is a core objective. Evaluations indicate reductions in the need to use restraint and a reduction in staff injury (Forest et al., 2018).

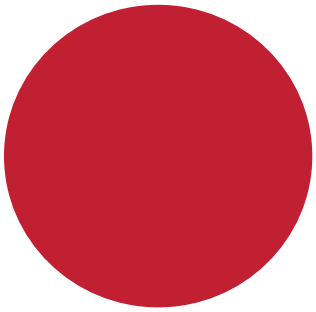
6. **Positive Peer Culture (PCC).** This approach draws on the power of the group as a vehicle for change, and in doing so involves the whole organisation. A well-documented plan is transparent and available to all staff, who are required to commit to the group work process. Recent studies show promising outcomes for young people in group care in terms of increased prosocial behaviours; however, are mixed in relation to juvenile justice outcomes, where group processes are not always found to be positive (Ryan, 2006 cited in James 2011).

7. **Dyadic Developmental Psychotherapy** is a practice model that was implemented as an approach to care in Illinois, USA, where it was implemented via a detailed staff training program with an explicit theoretical basis and a requirement that all staff adopt the PACE approach to working with young people (Clarke, 2011). A small-scale program evaluation found that on completion of the program that children had statically significant positive changes in behaviour, mental health, and capacity to resolve conflict and socialise (Blackwell & McGill, 2008).

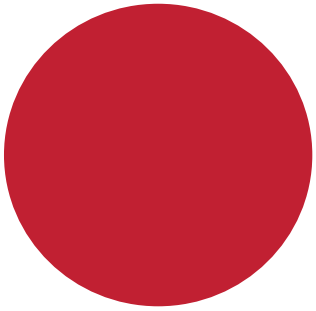
8. **Dialectical Behaviour Therapy** has been adapted for use in group care as part of a 12-month residential care program in the USA (McCredie, Quinn & Covington, 2017). The approach is manualised and has extensively documented the four core modules offered over four stages of treatment. Extensively researched with reference to adult populations, there is now emerging evidence with respect to adolescent group care, indicating reduced clinical symptoms and a greater capacity to use learnt skills for young people who completed the program (Quinn & Covington, 2017).

9. **The Neuro sequential Model of Therapeutics (NMT)** is an approach to the assessment and treatment of children that has been adapted to group care settings in the USA and the United Kingdom (Hambrick et al., 2018). Training in the approach is certified, thoroughly planned, documented and is based on emerging research and theory in neurobiology, traumatology and neuroscience. A small, retrospective study indicated promising findings in relation to problem behaviour reduction and school and family functioning (Hambrick et al., 2018).

10. **Stop-Gap** is a short-term therapeutic approach intensively delivered within the care setting and across the wider environment in preparation for discharge. The token economy behavioural modification approach seeks to reward positive behaviours across three tiers of intervention, which clearly document a learning program for young people. One evaluation noted a reduction in the use of restraint practices following a one-year period of implementation (McCurdy & McIntyre, 2004).



11. **Teaching Family Model** is an approach which has been widely implemented across the USA, Canada and the Netherlands, and as a manualised model has clear planning and implementation documentation which includes annual reaccreditation processes and training programs for professional carers. Evaluations over time are promising and indicate reduction in problem behaviours and mental illness symptomology (Lazselere et al., 2004 cited in James 2011).



12. **The Spiral Model** is described as an Australian evidence-informed framework for therapeutic residential care, which recognises that a high proportion of children placed in care are Aboriginal and Torres Strait Islander. The model focuses on cultural safety, involves a whole-of-organisation approach and explicitly seeks to recruit and support Aboriginal and Torres Strait Islander staff (Downey, Jago & Poppi, 2015). Only one publication was identified in relation to this recently developed model which outlined the development and implementation, however it does not include evaluation or research findings.

13. **The Circle of Courage** is based on traditional Native American beliefs and philosophy. In a residential care setting it promotes a sense of belonging, the development of mastery independence, and a sense of generosity for First Nations children and young people (Lee & Perales, 2005). It is described as a model for promoting resiliency and empowerment that 'originated from Native American culture' (Lee & Perales, 2005, p. 2). One study involving 29 youth in a mixed-method assessment – of the extent to which young people in residential care programs had integrated the four key components of the Circle of Courage components – was conducted over an eight-month period, yielding positive results.

What Were the Common Elements of the 'Promising Approaches'?

Eleven of the thirteen approaches were international and the remaining two were Australian. Almost all of the promising approaches identified a trauma-informed approach, and had clarity of implementation documentation and strategy and evaluation outcomes. The clarity of documentation most often went beyond a description of the core elements of the approach. It typically included a comprehensive theoretical and research evidence base, which had formed the basis of the construction of the approach. The 'elements' of the approach then appeared to be constructively aligned with a sound theoretical and empirical foundation. Common to the majority of the approaches, in summary, was the use of trauma theory, trained staff and the establishment of a therapeutic milieu as the foundation of care, supported by a congruent, whole-of-organisation commitment.

A critical consideration, documented by just four of the approaches included in this review, is the need to incorporate cultural considerations into the design and delivery of therapeutic care for First Nations children globally. In Australia, for Aboriginal and Torres Strait Islander children this must include an understanding of intergenerational trauma and the central place of cultural identity and connectedness in the lives of families and communities.

Conclusion

This systematic scoping review of the contemporary literature aimed to address the question 'What is the evidence base for therapeutic care?' The response to this question is that the evidence base is emerging.

To address the question the review identified four distinct domains of enquiry. Eight databases were systematically searched. A breadth and depth of material supporting an orientation to therapeutic care that is trauma-informed, as opposed primarily behaviourally or learning-focused, was found. That said, there are a range of practice approaches that each identify as trauma-informed; that is, they were not homogenous.

In examining documented approaches in terms of their implementation, evaluation and research outcomes the review found limited 'evidence' as it is traditionally defined in terms of health-oriented research hierarchies. The dearth of randomised, controlled research designs and longitudinal outcome studies is likely to reflect the complexity of the 'real world' of practice with children who have experienced trauma.

Within this context the review reports on thirteen 'promising approaches'. Eleven of the thirteen were international approaches and the remaining two Australian. Almost all of the promising approaches identified a trauma-informed approach, had clarity of implementation documentation, and strategy and evaluation outcomes.

A critical consideration, documented by just four of the approaches to care, is the need to incorporate cultural considerations into the design and delivery of therapeutic care. For Aboriginal and Torres Strait Islander children this must include an understanding of intergenerational trauma and the central place of cultural connectedness in the lives of families and communities.

Further research is needed to inform policy and program development in this critical arena.

PRIORITY RESEARCH AREAS INCLUDE:

- **Understanding specifically configurations of how different experiences of trauma lead to different consequences for young people's development and functioning and how to best attend to them**
- **Developing, implementing and evaluating cultural models of therapeutic care**
- **Designing longitudinal studies which can track pathways into and out of therapeutic care; and**
- **Workforce development approaches which enhance staff capacity to work effectively and therapeutically in consistent environments that maximise the potential of the young people in care.**

Introduction

Therapeutic care programs have been in existence throughout the United States of America, the United Kingdom, the Nordic countries and other parts of Europe for many decades, and have operated in a variety of settings, ranging from large, congregate care models to intensive therapeutic communities – inclusive of education and other services (James, 2011). The historical, socio-political and cultural contexts within which out-of-home care operates across the world vary widely, rendering international comparisons difficult to make. That said, in a recent cross-national summit the following definition was accepted as a starting point for a shared understanding of therapeutic care in the residential care context:

Therapeutic residential care involves the planned use of a purposefully constructed, multidimensional living environment designed to enhance or provide treatment, education, socialisation, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community based formal and informal helping resources (Whittaker, Del Valle & Holmes, in Whittaker et al., 2016, p. 94).

These authors go on to say that:

> ***…Therapeutic residential care is typically delivered through communitybased centres (children's homes) utilising community schools, or through campus-based programs which provide on-site school programs. We view therapeutic residential care in either form as a specialized segment of residential or group care services for children, although we consider our principles underpinning TRC as being relevant for all forms of residential child care. Whilst sharing certain characteristics, these services vary greatly in treatment philosophies and practices including their purposes and intensity and duration of interventions provided….***
>
> ***(Whittaker et al., 2016, pp. 94–95)***

Even with a consensus on definition, opinions as to what is effective therapeutic care vary, with strongly held views expressed against and for models of group care – as potentially helpful versus damaging for young people (Ainsworth & Hansen, 2018; Hurley, Lambert, Gross, Thompson & Farmer, 2017).

The emergence of 'therapeutic care' as a form of out-of-home care in Australia is a relatively new development. In this country, models of care have traditionally been offered to provide care, containment and support, whilst the therapeutic needs of children were seen as the domain of specialist mental health clinicians (Morton, Clark & Pead, 1999). As recently as the 1990s some states and territories began to recognise that 'care was not enough' to meet the needs of children and young people who had experienced complex trauma. In Victoria, for example it was found that

> ***…There are a number of children and adolescents in care, who have suffered traumatic early environments, for whom care is not enough to effectively address the aftermath. It is argued that these young people need consistent and high quality care, which offers continuity of positive relationships. However, they also need systematic therapeutic interventions, to assist them to rebuild their lives and address post-traumatic states and developmental disturbance associated with the severe abuse and neglect they have suffered…***
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> ***(Morton, Clark & Pead, 1999, p. 5)***

These findings paved the way, in that state, for a more integrated, therapeutic response by those who work directly with children and to young people outside the traditional one-hour weekly therapy appointment, in the 'other 23 hours' (Bath, 2015; Trieschman, Whittaker & Brendtro, 1969).

Services offering out-of-home care options have been oriented towards home-based care, reflecting the national and international impact of de-institutionalisation. Australia has recently seen the rise and rise of kinship care as a preferred option of out-of-home care, with current figures indicating that 47% of children placed are now with relative or family friend carers and a further 38% are in foster care (AIHW, 2018).

One implication of this is that many of those children and young people who are placed in group or residential forms of care, at just 5% of the care population (AIHW, 2018), are the most troubled and present with complex and challenging needs. Ironically, they have often been placed in residential care as a service of 'last resort'. It is within this context that Australian service providers have increasingly recognised the need to respond to our most vulnerable young people – with clear demonstration of complex needs – with more than a simple 'care' response. In the past decade alone, each Australian state and territory has shown a growing interest in and adoption of therapeutic models of care (McLean, 2018; McLean, Price-Robertson & Robinson, 2011).

Therapeutic residential care has been defined in Australia as

> ***…Intensive and time-limited care for a child or young person in statutory care that responds to the complex issues of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment and development needs…***
>
> ***(National Therapeutic Residential Care Working Group, cited in McLean, Price-Robertson & Robinson, 2011)***

The purpose of this review was to systematically scope the Australian and international literature in relation to therapeutic care. The focus of the review was in relation to group or residential care, as opposed to the wider application of therapeutic approaches. As a scoping review we have not endeavoured to make comparisons between approaches to therapeutic group care (Woodgate, Morakino & Martin, 2017). Rather, we have mapped and synthesised the publications available and present here core elements of approaches identified. What follows is an overview of the systematic scoping review methodology before we present our findings and discussion, where we propose a methodology with which to map promising approaches to therapeutic group care. Finally, we conclude with implications for further research.

Key Terms

We have used the Australian Institute for Health and Welfare (AIHW) definitions of out-of-home care and residential care:

> ***…Some children are placed in out-of-home care because they were the subject of a child protection substantiation, and need a more protective environment. Children may also be placed in out-of-home care when their parents are incapable of providing adequate care for them, or when alternative accommodation is needed during times of family conflict. Out-of-home care is considered an intervention of last resort, with the current emphasis being to keep children with their families wherever possible. When children need to be placed in out-of-home care, an attempt is made to subsequently reunite children with their families. If it is necessary to remove a child from their family, placement within the wider family or community is preferred. This is particularly the case with Aboriginal and Torres Strait Islander children, as outlined in the Aboriginal and Torres Strait Islander Child Placement Principle…***
>
> (AIHW, 2018, p. 3)

Residential or group care is where ‘placement is in a residential building where the purpose is to provide placements for children and where there are paid staff (AIHW, 2018, p. 43).

Literature Review Methodology

This systematic scoping review aimed to examine and understand the nature and scope of existing research on therapeutic residential care across international, English-speaking jurisdictions. It also aimed to scope children and young people's adverse childhood experiences (ACEs), and implications and needs for a therapeutic response. Diversity of ethnicity, cultural background, sexual orientation and disability was also examined in the literature review.

The review methodology was informed by the methodological approach established by Arksey and O'Malley (2005) and more recently applied by Daudt, van Mossel and Scott (2013). The final outcome of the systematic scoping process resulted from an identification of research questions, inclusion and exclusion criteria, data charting and collation via the Preferred Reporting Items for Systematic Reviews and Meta-Analysis or PRISMA chart (Daudt et al., 2013). Undertaking a systematic scoping review ensures a comprehensive perspective of what has already been studied and the identification of research gaps and future research, policy and practice implications.

Phase one

Identifying research questions

The first phase of the review was to identify the research questions. Firstly, sourcing literature which spanned content involving the different identifiers for residential care across international jurisdictions: 'therapeutic residential care', 'child', 'youth', 'young person', 'group care' and 'looked after children', were the initial search terms. Eight databases were selected for inclusion in the systematic scoping review. Total results found from each database using the search string identified above were recorded. The following databases sourced a wide range of literature via the above search string: Academic Search Premier, CINAHL, Expanded Academic Complete, InfoRMIT, Medline, ProQuest, PsycInfo and Scopus.

Following an initial scan, four separate fields of inquiry were established with aims to closely examine the experience of children and young people living in residential care settings. The overarching research question was:

What is the evidence base for therapeutic care?

In order to comprehensively address this question, four sub-questions or domains were identified as follows:

1. What are the backgrounds of children and young people in group care? What are the implications of their backgrounds for their care needs?
2. What are the needs of Aboriginal and Torres Strait Islander children and young people in care?
3. What are the needs of children of diverse backgrounds?
4. What is known about effective 'therapeutic' models of residential or group care?

Searches were conducted on the four domain areas via the eight selected databases.

THE KEY SEARCH TERMS FOR THE OVERALL QUESTION WERE:

"Therapeutic residential care" OR "Residential care" OR "group homes" AND "child*" OR "youth" OR "young people" OR "looked after children"

The additional search terms for sub questions were

- What are the backgrounds of children and young people in group care? What are the implications of their backgrounds for their care needs? **"Violence" OR "trauma" OR "substance abuse" OR "sexual aggression" OR "emotional dysregulation" OR "Self Harm" OR "adverse childhood experience".**
- What are the needs of Aboriginal and Torres Strait Islander children and young people in care? **"Aboriginal" OR "Indigenous" or "First nations" OR "Torres Strait".**
- What are the needs of children of diverse backgrounds? **"Asylum seekers" OR "unaccompanied minors" OR "Culturally Diverse" OR "Disability" OR "Queer" OR LGBTQI.**
- What is known about effective 'therapeutic' models of residential or group care? **"Trajectory" OR "Outcomes" OR "Evidence" OR "What works" OR "Leaving care" OR "Transition" OR "Therapeutic Programs" OR "Models".**

Phase two

Identifying methods of inclusion and exclusion

Following the general searches of the domain areas, inclusion and exclusion criteria were refined by the research team. The key inclusion criteria included: academic journal articles only, peer-reviewed, publishing years between 2008 and 2018, and articles written in English. An examination of grey literature was conducted simultaneously with the systematic review of academic, peer-reviewed literature and was assessed separately. Once the inclusion criteria were agreed upon, searches were conducted on each of the eight databases using the inclusion criteria against the five question domain areas.

Phase three

Collating results

As literature searches were running, the total numbers of results, incorporating the inclusion criteria, were exported to a shared library using Endnote v.X9. Results were collated via their corresponding database. Articles were included based on how close in relevance the abstract was to the research question.

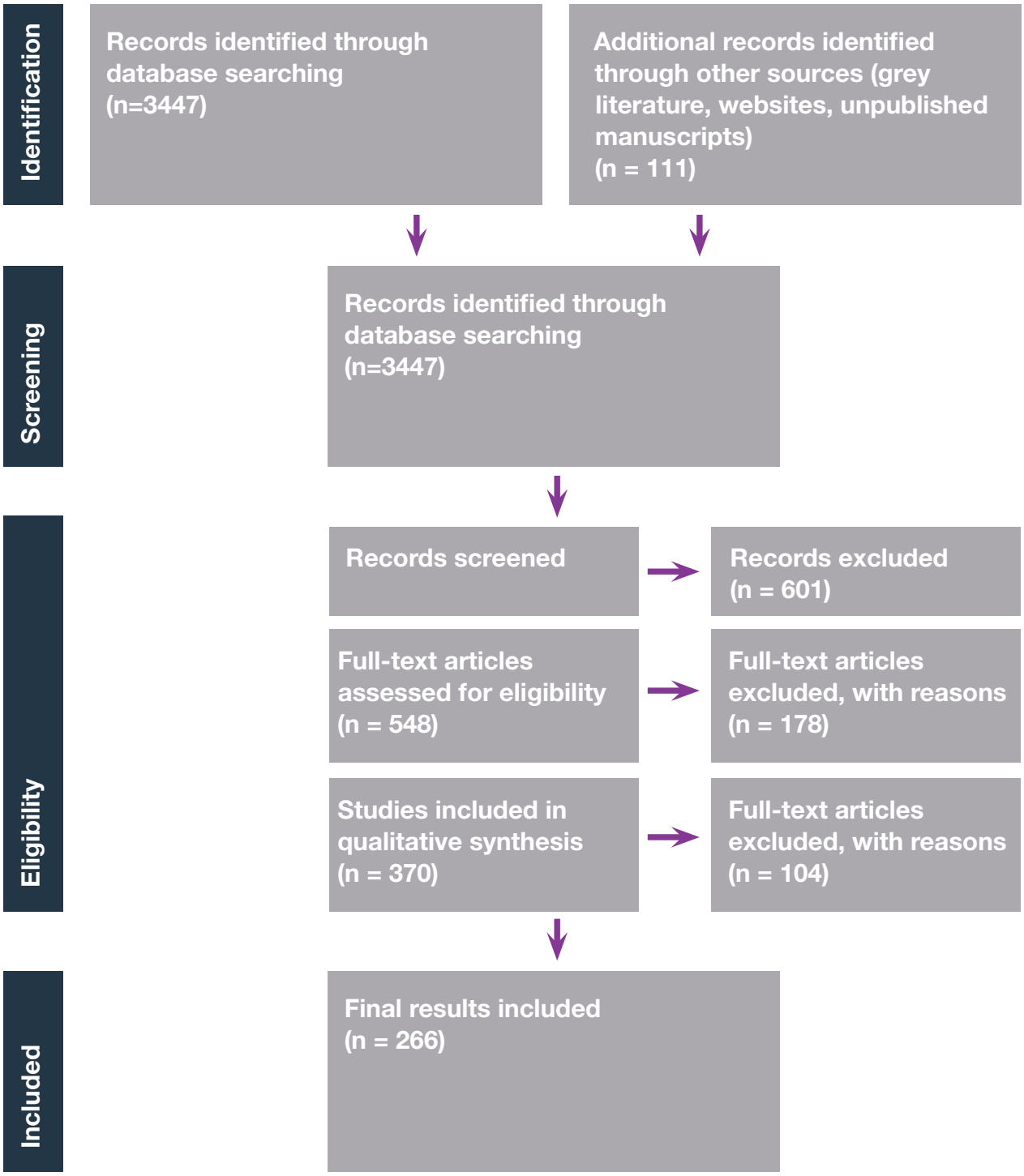
Once exclusions and title and abstract analysis of texts were completed, full PDF texts were sourced for the remaining text results. From there, further exclusions were examined based on relevance to the research domain. The selected texts from each domain area were then used in

the final literature analysis, creating a holistic frame of reference for past studies of experience and implications for children living in residential care.

Phase four

This phase summarises the search and exclusion process via the contraction of the PRISMA.

Charting and analysing the data PRISMA



Limitations of the review

There were a number of identified limitations identified in the review process. The most notable was the likelihood that there will be approaches to therapeutic care that this review has not identified. It is not suggested that these approaches do not have merit, but that it may be that there are no peer-reviewed publications identifying the development and evaluation of the approach, or that the search strategy employed did not identify those publications. A second limitation was that only publications in English were sought. This may have excluded approaches of interest that had been published in languages other than English.

Findings and Discussion

In this section we present and discuss the findings of this review.

In **Part One**, we focus what is known about children and young people in residential or group care. We will initially hear from young people themselves who, via two recent Australian studies, expressed their views about their care experience. We then explore the literature in relation children who have experienced adversity, before discussing the implications for children in therapeutic care. There is particular focus on the context for and needs of Aboriginal and Torres Strait Islander children and a brief overview of issues faced by children with a disability, queer children and those who are unaccompanied minors.

Part Two presents the therapeutic group care approaches that this review identified for inclusion. The contested issue of 'evidence' is discussed, and approaches are examined in the context of the rigour of their implementation and the quality and availability of evaluation outcomes. We conclude with a brief overview of the research examining leaving care. This report concludes with a summary of the key issues identified and implications for policy, practice and future research.

Part One: What are the Needs of Children and Young people in Group Care?

Approximately one in twenty children and young people (2,394 of 43,400 young people in the out-of-home care system Australia-wide) living in out-of-home care reside in residential care homes (AIHW, 2018). In Australia, residential care has historically been reserved for adolescents whose behaviours pose a danger to the community, are self-injurious, or otherwise require a highly structured environment and for whom a family-based placement is not seen as able to contain or to manage their challenging behaviours (Underwood, Barretti, Storms, & Safonte-Strumolo, 2004). Whilst a proportion of children are placed in residential care to enable sibling groups to remain together, they are often considered difficult to care for, presenting with treatment-refractory behavioural and/or emotional dysregulation problems (Anastasio, Baker, Dale & Purcell, 2007; Baker, Wulczyn & Dale, 2005; Stewart et al., 2010).

What are young people telling us about their care experience?

A recent Australian study consulting young people living in residential care identified that a number reported that they did not feel safe, and that physical, psychological and sexual violence were perceived to be real risks for them, both between young people in care and between young people and workers and other adults (Moore, McArthur, Roche, Death & Tilbury, 2016). This study concluded that children and young people living in residential care were at risk of being pressured into having sex, being sexually manipulated or physically assaulted, and were at greater risk of sexual exploitation compared to their peers living in other forms of care (Moore et al., 2016, pp. 79–81).

In another Australian study, young people currently living in residential care, aged 15 to 17 years, were surveyed about their current experience in care. Of the 321 young people who responded (a response rate of 67%), about a quarter responded negatively (Robertson, Laing, Butler & Soliman, 2017). Concerns included not having a lot of say in decisions affecting them, more than a quarter reported not feeling safe and settled (28%), and almost a quarter were not satisfied with the level of contact they have with their family (23%). Whilst these rates of dissatisfaction do present some concern, it should be acknowledged that the majority of children and young people still responded positively to most indicators.

What do young people recommend?

In terms of recommendations about what they value or need from their care experience, both international and Australian research indicates that young people value positive and lasting relationships, an experience of stability and predictability whilst in residential care, and the facilitation of an emotionally and physically safe environment (Berridge, 2004; Mason, 2007; Sinclair, 2005). Young people are telling us that they want to participate in decision making about their lives and to be listened to and respected (Moore et al., 2017), and that connection to their siblings and friends is important (Chapman, Wall & Barth, 2004). A desire for normality is highlighted (Berridge, 2005; Sinclair, 2005) as is a need for flexible carers who respect young people's cultural heritage whilst offering a genuine and caring relationship (Mason, 2007; Sinclair, 2005). Finally, young people in care want opportunities to have a positive future where they can identify and strive toward their personal goals (Berridge, 2005; Sinclair, 2005).

What has happened to the children and young people in group care?

Brain Development and Trauma

A dominant perspective held in the contemporary literature is that these children and young people have been exposed to multiple adverse events, resulting in complex trauma (Gaskill & Perry, 2012). While the field of neuroscience is still growing rapidly, we already have a lot of good information that can help us understand children's early brain development.

Advances have helped to change understandings of how the brain develops during childhood and adolescence, and how physiological changes in response to stress can interact with a child's neurodevelopment. These neurodevelopmental principles have been advanced through new neuroimaging technologies and research methods (Hart & Rubia, 2012). The brain develops and modifies itself in response to experience. Neurons and neuronal connections (synapses) change in an activity-dependent fashion. This 'use dependent' development is the key to understanding the impact of neglect and trauma on children.

The developing brain is use-dependent, which means that when specific neural systems are frequently activated in response to environmental stimuli or stressors, these systems have the potential to become more permanent neural states for children (Gaskill & Perry, 2012). The development of the brain during infancy and childhood follows the bottom-up structure. The most regulatory, bottom regions of the brain develop first; followed, in sequence, by adjacent but higher, more complex regions becoming organised and more functionally capable. Therefore, contrary to previous thought, 'lower' brain systems involved in stress responses may not be wholly controlled by 'higher' brain systems, such as those involved in reasoning and inhibition. In times of acute stress, these lower-order systems can override other brain systems that are beyond a child's conscious awareness (Gaskill & Perry, 2012). This means that the brain does not interpret, store and respond to information in a hierarchical fashion, but is characterised by integrated responses involving various brain systems (van der Kolk, 2003).

Children's brains may be particularly susceptible to the timing and severity of trauma exposure as brain development in childhood is not linear (Pechtel & Pizzagalli, 2011). This activation of key neural systems in the brain leads to adaptive changes in emotional, behavioural and cognitive functioning to promote survival. Yet, persisting or chronic activation of this adaptive fear response can result in the maladaptive persistence of a fear state. This activation causes hypervigilance, increased muscle tone, a focus on threat related cues (typically non-verbal), anxiety, and behavioural impulsivity – all of which are adaptive during a threatening event yet become maladaptive when the immediate threat has passed.

What is Trauma?

The conceptualising of children and young people in out-of-home care as having experienced complex trauma is supported by decades of international research and clinical observation (Gaskill & Perry, 2012; Perry, 2009; Van Horn, 2011).

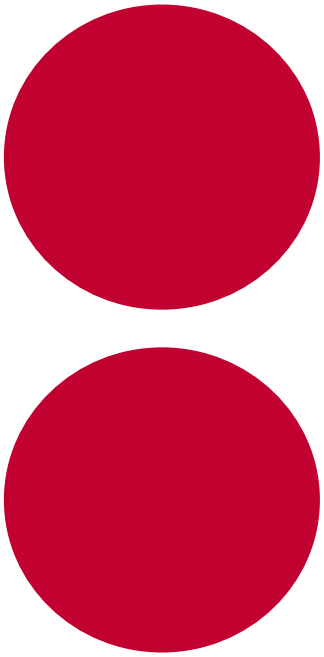
CHILDHOOD TRAUMA IS TYPICALLY CHARACTERISED BY TWO PRINCIPAL CRITERIA:

- **the experience, which includes the type and duration of trauma experienced, and**
- **the child's reaction to trauma exposure, such that these experiences overwhelm a child's ability to cope, and cause the child to feel extreme fear, helplessness or horror (American Psychological Association, 2008).**

Traumatic experiences – sometimes classified as simple or complex trauma (Australian Childhood Foundation, 2010) – are events that threaten the physical integrity of the child or others close to them with harm, injury or death (American Psychological Association, 2008).

Simple trauma typically refers to discrete life-threatening events such as accidents, or natural or man-made disasters. Experiences may include illness or disease, car accidents, bushfires, floods, industrial accidents, war or terrorism.

Complex trauma involves repeated or ongoing threats of violation or violence between a child and another person. It may include experiences such as bullying; emotional, physical or sexual abuse; child maltreatment or neglect; or witnessing domestic violence. Complex trauma that disrupts the development of secure attachment to a parent or primary caregiver has the potential to have profound developmental consequences for a child (De Bellis, 2001), and is the most stressful trauma that a child can experience (Van Horn, 2011). Complex trauma can occur through the loss or death of a parent (Gregorowski & Seedat, 2013), or when the parent or caregiver is the primary perpetrator of trauma.



Van der Kolk (2003) posited that complex trauma creates an 'assault' on the child's development over time. Not only do traumatised children develop a range of unhealthy coping strategies which they believe will help them survive, they also do not develop the essential daily living skills that children need, such as being able to manage impulses, solve problems and use executive functioning.

Early trauma and stress can have a lasting effect on development, triggering delays in social competence (Becker-Weidman, 2009), development of dysfunctional coping behaviours, and significantly altering a child's brain chemistry; particularly when the adverse condition is chronic and there is a lack of nurturing support (Bremner, 2003; Carrion, 2006).

COMPLEX TRAUMA IS AN UMBRELLA TERM FOR THESE SEVEN AREAS OF IMPACT:

- **Sensory Development**
- **Dissociation**
- **Attachment Development**
- **Emotional Regulation**
- **Behavioural Regulation**
- **Cognition**
- **Self-Concept and Identity Development (cook et al 2005).**

As well as these developmental difficulties, the child or young person can also experience discrete mental health difficulties, often connected to episodes of anxiety, depression, and specific traumatic symptoms (e.g., flashbacks, intrusive thoughts, nightmares). So, often these symptoms are understood and treated as isolated 'anxiety' or 'depression'; however, for chronically traumatised children and young people this does not tend to be an effective way to address their difficulties. Seeing mental health symptoms as part of an overall picture of developmental trauma is the key (Spinazzola, van der Kolk & Ford 2018).

Childhood adversity not only impacts the sufferer at the time of its occurrence, its effects can continue to be felt right across the lifespan. The negative impacts of childhood adversity are manifold and can be considered from psychological, emotional, social and behavioural perspectives. The work of a number of researchers is focused on identifying the neural changes with which these are correlated.

Neuropsychological outcomes

New understandings in developmental and neuroscience research have challenged popular ideas about trauma exposure and brain development during childhood. There is a general misconception that children are more resilient than adults to the effects of trauma and will 'outgrow' traumatic experiences (Lieberman & Knorr, 2007).

Chronic activation of a child's stress systems can cause cascading effects within interconnected biological systems. Changes in how these stress systems operate can eventually impact the structure of the brain through causing atrophy or hypertrophy in particular parts of the brain (Tarullo & Gunnar, 2006; Rogosch, Dacksis & Cicchetti, 2011). Areas of the brain understood to be most frequently affected include the hippocampus, amygdala, and corpus callosum (Hart & Rubia, 2012). These brain areas are key, variously, to memory, emotional interpretation and regulation, and higher-level cognitive processing, and are implicated in a range of psychological and social problems. The dysregulation can also cause wear and tear on other organs of the body (Shonkoff & Garner, 2012), which can lead to a range of health problems.

Psychological outcomes

A number of researchers have found that children who have experienced significant adverse circumstances are more likely than others to fall prey to depressive disorders, anxiety disorders and other mental health issues across their lifespan (Schilling, Aseltine & Gore, 2007). In a meta-review, Teicher and Samson (2013) found that individuals with a history of child abuse experience psychiatric problems differently to those who do not have a history of maltreatment. They have an earlier age of onset of their condition, greater severity of symptoms and a greater rate of comorbidity. They also have a higher risk of suicide and a poorer response to treatment compared to those were not subject to abuse. Other researchers have linked childhood trauma with psychosis in adults (Bendall, Jackson, Hulbert & McGorry, 2011).

Physical Health Outcomes

Children who have experienced childhood adversity also face a range of physical health problems including higher risk of lung cancer (only partly mediated by smoking) (Brown et al., 2010), obesity (Fuemmeler, Dedert, McClernon & Beckham, 2009) liver disease, poor dental health (Shonkoff & Garner, 2012), chronic obstructive pulmonary disease (Yao & Rahman, 2009) and autoimmune diseases (Dube et al., 2009). Flaherty and colleagues (2006) found in an examination of data on over 1,000 children, collected for a longitudinal study, that exposure to one type of adverse experience – whether a type of direct abuse or parental dysfunction – doubled a child's risk of overall poor health, where four such experiences tripled their risk of having an illness that required medical attention.

Drug addiction, which can have a range of negative implications for those with physical health, is also experienced at a higher rate amongst those who have experienced abuse than in the general population. Brown and colleagues, examining data collected for the original ACE study found that those with high ACE scores (more than six) died, on average, 20 years earlier than others (Brown et al., 2009).

Forkey and Szilagyi (2014) comment specifically on the poor health of those who have spent time in foster care, stating that they have much higher rates of acute and chronic illness than other children their age. Common problems include high rates of infection, asthma and obesity. They state that where some physical problems are the result of physical trauma, other problems – those related to dysregulation of the immune response and chronic inflammation – are related to psychological trauma. A number of other reviews, such as that undertaken by Deutsch and Fortin (2015), have

found that children in foster care suffer worse health than other populations, and emphasise the relationship between health and other developmental outcomes.

Social outcomes

D'Andrea and colleagues (2012) refer to a range of behaviours and interpersonal challenges commonly experienced by children who have experienced interpersonal trauma. These include 'disrupted attachment styles, difficulty trusting people, fewer social skills, difficulty with seeing others' perspectives, an expectation of harm from others and poor understanding of boundaries' (p. 190). Shonkoff and Garner (2012) discuss that many of the social problems that those who had significant adverse childhood experiences confront – such as difficulty with maintaining supportive networks – are related to risk-taking behaviour they have engaged in as coping mechanisms.

Cognitive Attentional Outcomes

Trauma has been found to affect cognitive functioning in a range of ways. Hart and Rubia (2012), in a review of current evidence, found that children who have been abused experience problems related to their IQ, general memory, working memory and attention (see also Porter, Lawson & Bigler, 2005). Several researchers' report that children who have experienced abuse are also more likely to find that their executive functioning – their capacities for planning and decision-making – are compromised (Nikulina & Widom, 2013). A number of studies have also found that children who have experienced abuse have IQs that are negatively correlated with level of abuse (Prasad, Kramer & Ewing-Cobbs, 2005; Koenen et al., 2003). Another problem related to a history of abuse is negative cognitive bias. Those such as Ayoub and colleagues (2006) have demonstrated that children exposed to violence can be biased towards information and narratives with a negative character, as well as having a reduced capacity to recall information that has positive salience.

Children who have experienced trauma also have poorer educational outcomes. In a longitudinal study, Goodman, Miller and West-Olanunji (2011) found that a sample of Grade 5 students who had experienced traumatic stress did poorly on a range of measures compared to their peers. Children who have been in care have also been found to struggle in school. CREATE Foundation (2012) found that those young people in care are less likely to continue with their education past the age at which they can drop out, are likely to be older than those in their year level, attend more schools than others and miss significant amounts of school as a result of changes in placements.

In summary, as a consequence of exposure to complex trauma, children in care manifest complex psychopathology, characterised by attachment difficulties, relationship insecurity, sexual behaviour, trauma-related anxiety, conduct problems and defiance, and inattention/hyperactivity, as well as uncommon problems such as self-injury and food maintenance behaviours. Children in residential care have more mental health problems than those in family-type foster care, while those in kinship care have fewer problems. (Tarren-Sweeney, 2008). The literature suggests that children and young people in OOHC are likely to experience:

- compromised executive functioning; difficulty regulating arousal levels in response to emotional and sensory stimulation (high and low emotional responsiveness); difficulty with attention and memory; distinct patterns of social information processing; and reactivity to sensory stimuli;
- disruptions to sleep and other circadian rhythms; and
- compromised language development, including difficulty in the comprehension and social use of language despite apparently adequate verbal abilities (Cook et al., 2005; De Lisi & Vaughn, 2011; Lansdown, Burnell & Allen, 2007; McCrory et al., 2010; McLean & McDougall, 2014; Noll et al., 2006; Ogilvie, Stewart, Chan & Shum, 2011; Perry & Dobson, 2013).

What are the implications for trauma-informed therapeutic care?

Children and young people suffering from complex trauma often have difficulties related to attachment, regulation, physiology, dissociation, behavioural control, cognition and self - concept (Cook, Blaustein, Spinazolla & van der Kolk, 2003). The traumas that were experienced in a relationship can be treated in and through the use of a trusting, reparative relationship (Spinazolla et al., 2018; Mitchell, Tucci & MacNamara, In press). Thus, a focus of the establishment of therapeutic care programs is the centrality of relationships as a vehicle for healing. Therapeutic residential care has been described as being

> ***…Defined by its therapeutic milieu. …There is well defined therapeutic intervention followed and therapists form part of the service provision that every child or young person receives. Therapists are an integral part of the care team and meet weekly with residential and educational staff…therapy is incorporated in every context with residential carers often being called residential therapists or professional parents…***
>
> ***(Hillman 2006, pp. 57–58 cited in ACF 2015)***

Some authors suggest that a 'whole-of-organisation approach' to the provision of therapeutic care is required in order to ensure that staff at all levels of the agency experience support and safety in their practice (Bloom & Farragher, 2013).

Three components of the therapeutic milieu, enabling trust-based relational intervention, are said to be empowerment, connection and correction (Cook, Blaustein, Spinazolla & van der Kolk, 2003). Building on the concepts identified by those seminal authors who identified the need to develop sound direct care approaches to practice with children and young people in what is known as 'the other 23 hours' (Trieschman, Whittaker & Brendtro, 1969), Howard Bath proposed 'The Three Pillars' as an orientation to healing from complex trauma (Bath, 2015). Challenging traditional mental health treatment paradigms, Bath suggests that 'Healing starts with creating an atmosphere of safety: formal therapy is unlikely to be successful unless this critical element is in place' (Bath, 2015, p. 6). The 'Three Pillars' for developing and maintaining an environment that facilitates healing are:

1. Safety entails an environment where one can feel secure, calm and attend to normal developmental tasks.
2. Connections involve trusting relationships with caring adults as well as normative community support such as sports teams, youth groups and recreational programs. Building connections fosters resilience by meeting growth needs for belonging and generosity.
3. Coping enables the individual to meet life challenges as well as to manage emotions and impulses underlying traumatic stress. In resilience terms, successful coping strengthens growth needs for mastery and independence (Bath, 2015, p. 6).

A recent review of therapeutic approaches to residential care in both Northern Ireland and Victoria, Australia, identified 'ten essential elements' of evidence-informed therapeutic practice in residential care (Verso Consulting, 2016). These ten essential elements, combined with therapeutic core principles, form the basis of a system of therapeutic care in New South Wales, Australia.

THE ESSENTIAL ELEMENTS IN SUMMARY ARE:

1. **The (appointment of a) Therapeutic Specialist.**
2. **Trained Staff and Consistent Rostering.**
3. **Engagement and Participation of Young People**
4. **Client Mix**
5. **Care Team Meetings**
6. **Reflective Practice**
7. **Organisational Congruence and Commitment**
8. **Physical Environment**
9. **Transition Planning, Exit Planning and Post Exit Support**
10. **Governance and Therapeutic Practice Improvement. (Verso Consulting, 2016, p. 5)**

In Part Two of this report, we explore models and approaches to therapeutic group care in some detail.

What do we know about the needs of Aboriginal and Torres Strait Islander children in group care?

Recent national data suggests that, overall, Aboriginal and Torres Strait Islander children (13.6 per 1,000) were 10 times as likely as non-Aboriginal and Torres Strait Islander children to be admitted to out-of-home care during 2016–17 (AIHW, 2018). Historical and political context is of critical importance in Australia. The Bringing Them Home report reminds us that:

> ***…The histories we trace are complex and pervasive…. The actions of the past resonate in the present and will continue to do so in the future [because] the laws, policies and practices which separated Aboriginal and Torres Strait Islander children from their families have contributed directly to the alienation of Aboriginal and Torres Strait Islander societies today (1997, p.4)…***

Numerous studies have highlighted that the violent colonial history and the intergenerational trauma evident in Aboriginal and Torres Strait Islander communities has had profound impact on their families and relationships (Atkinson, 2013; Bamblett & Lewis, 2007;

Bamblett, Long, Frederico & Salamone, 2014; Human Rights and Equal Opportunity Commission, 1997; Lewis, 2018). Judy Atkinson (2013) says that traumatic historical events continue to influence life experiences of Aboriginal families and children.

While theorising the impact of colonisation on Aboriginal and Torres Strait Islander families in Australia, Bamblett and Lewis (2007) describe Australia as an unsafe and 'toxic' environment for Aboriginal people due to the colonial undertones and the domination of Western policies and structures, which are punctuated by racism and culturally unsafe practices. It is within this colonial context that Aboriginal and Torres Strait Islander children were taken away under a racially defined act guised through the lens of the 'best interests of the child'. *The Bringing Them Home report* was the first report which clearly exposed the perverseness of the stolen generation and the extent of the resulting trauma and damage this had on Aboriginal and Torres Strait Islander families and communities (Bamblett & Lewis, 2007; Human Rights and Equal Opportunity Commission, 1997).

The Healing Foundation (2017), in *Bringing Them Home 20 years on: an action plan of healing,* reiterates that the displacement and disconnection from culture, language, family, community and country has caused intergenerational trauma, grief, loss and sadness which persists to date. Bamblett et al. (2014) add that the extensiveness and the pervasiveness of the individual and collective loss, grief and trauma within the Aboriginal community exposes Aboriginal children and young people to the likelihood of re-experiencing complex trauma in even more repeated, multiple and interactive ways. The Secretariat National Aboriginal and Islander Child Care (SNAICC, 2015) suggests that the adversities of the colonial history on Aboriginal and Torres Strait Islander communities have endured and remain the dominant paradigm in community and cultural care for Aboriginal and Torres Strait Islander children. To amend these historical injustices, the *2018 Family Matters Report* has emphasised that the traumas of colonisation and forced removal of Aboriginal and Torres Strait Islander children, the historical and structural racism, entrenched poverty and systemic disadvantage are to be addressed if cultural healing is to occur (Lewis et al., 2018).

Looking to the Canadian context, deFinney et al. (2011) offer a similar view. They argue that Canada is 'dominated by normative social values and practices that have systematically, over many generations, positioned Aboriginal and Torres Strait Islander cultural and social norms as inferior' (p. 369). Similar to Australian history, colonial policies in Canada have previously enabled the forceful removal of children from their families (Downe, 2005). Child Youth and Family Health (n.d.) showed that the imposition of colonial and foreign laws and policies continue to affect Aboriginal and Torres Strait Islander Families in Canada to date. deFinney et al. (2011, p. 369) while citing the Indian and Northern Affairs Canada, (2008, p. 172) state that:

Aboriginal and Torres Strait Islander Peoples in Canada are still governed by the 1876 federal Indian Act, which 'rests on the principle that the Aborigines are to be kept in a condition of tutelage and treated as wards or children of the state… [and that] the racist ideology of the Indian Act characterizes a contemporary context in which Aboriginal and Torres Strait Islander children continue to be grossly over-represented in child welfare cases and out-of-home placements.

As such, child welfare systems should radically transform the colonial remnants that continue to punctuate the process of child protection in most developed countries. That there is such an over-representation of Aboriginals in care is an indication that something in the design and delivery of out-of-home care interventions is not addressing critical issues that affect Aboriginal and Torres Strait Islander families and communities, and is very possibly contributing to reproducing their very marginalisation and minoritisation.

Fernandez and Atwool (2013) provide further contextualisation of Aboriginal and Torres Strait Islander children in care. They state that the entrenched and intergenerational socioeconomic problems, dire poverty, social, economic and political marginalisation, lack of political goodwill in addressing historical injustices, and the mostly white child rearing structures which dominate child welfare systems – which are unwilling to accept the diversity of parenting and family structures between Aboriginal and non-Aboriginal societies – have had a significant contribution to the over-representation of Aboriginal and Torres Strait Islander children in care in Australia. Put simply, as much as contextualising the issue is about understanding a historical context, it is also about acknowledging that the approach towards protecting Aboriginal and Torres Strait Islander children and young people needs a multi-pronged approach; one that aims to acknowledge the intersectionality between the needs of Aboriginal and Torres Strait Islander children in care, and the complex systemic disadvantage that is punctuated by both historical and current contexts.

The over-representation of Aboriginal and Torres Strait Islander children in care

The overwhelming removal of Aboriginal and Torres Strait Islander and First Nations children across many developed countries in the West remains well documented in literature (Fernandez & Atwool, 2013; Keddell & Davie, 2018; McDowall, 2016; Mosher, 2018; National Indian Child Welfare Association, 2007; Valerie & Regina, 2010).

In Australia, the Family Matters Report (2018), which measured the trends on the overrepresentation of Aboriginal and Torres Strait Islander children in out-of-home care in Australia, starts by offering this statement:

> ***…If the tide is not turned, we project the population of Aboriginal and Torres Strait Islander children living in out-of-home care will more than triple by 2037, and the level of over-representation will also increase…***

These numbers are particularly concerning because although Aboriginal and Torres Strait Islander and Aboriginal children only consist of about 3% of the total population in Australia, they represent 24% of the children placed in out-of-home care systems. These statistics allow us to contextualise the significance of the problem in Australia. In considering the soaring numbers of Aboriginal and Torres Strait Islander children in care systems, Krakouer, Wise & Connolly (2018) state with emphasis that:

> ***…Australia is in the midst of a child welfare crisis, with the inordinate number of Aboriginal and Torres Strait Islander children in care raising serious concerns that we are facing a second 'Stolen Generations'…the high numbers of Aboriginal and Torres Strait Islander children currently being observed in out-of-home care are symbolic and similar to the number of Aboriginal children that were removed during the stolen generation era…***

A significant contradiction is that although the number of non-Aboriginal and Torres Strait Islander children and young people in care has remained relatively unchanged over the last five years at 5.5 per 1,000, the rate for Aboriginal children and young people has skyrocketed from 24.1 to 52.5 per 1,000 children since 2006 (McDowall 2016). The most recent data available from the Australian Institute of Health and Welfare reports that Aboriginal and Torres Strait Islander children are now 10 times more likely than non- Aboriginal and Torres Strait Islander children to be placed in out-of-home care.

Systemic Challenges and Complexities

> ***…We are outraged by the discrimination still embedded in the system. And we despair that we are not being heard …***
>
> ***(Secretariat National Aboriginal and Islander Child Care (SNAICC), 2015)***

It is now clearly established that there are systemic issues, challenges and complexities that facilitate the reproduction of the overrepresentation of Aboriginal children in care. Superficial efforts that do not seek to address systemic issues of colonization, marginalisation, racism and structural disadvantage only fall short of any optimum results, and instead contribute in reproducing disadvantage and inequality for people and their families. Inherent to the structural complexities of overrepresentation are the policies, past and present, which may contain the remnants of over 200 years of colonization which are still observable in the way intervention programs are drawn and implemented. Research and stories from Aboriginal & Torres Strait islander people's strongly suggest that their children's overrepresentation in child welfare systems is not accidental but is a result of a complex structural interrelationship between *"historical and contemporary macro, meso, individual, and systemic factors"* (Krakouer et al. 2018) and a direct outcome of the lingering impacts of colonisation—*"which have resulted in [significant] socioeconomic disadvantage across multiple measures— coupled with institutional racism, bias, and a lack of cultural competence in tertiary-intervention dominated statutory systems"* (Krakouer et al. 2018, p. 266).

The Importance of Culturally Appropriate/Safe Interventions

The lack of respect for our culture and our knowledge is a major contributing factor to the over-representation of our children and young people in the child protection system. (Secretariat National Aboriginal and Islander Child Care (SNAICC), 2015).

In Victoria, Australia the child protection system faced a crisis. Data indicated that there had been a 59 per cent increace in the number of Aboriginal children and young people in out-of-home care from 2013 to 2015. The Victorian Comission for Children and Young People conducted a systemic inquiry into services provided to Aboriginal children and young people in out-of-home care, it was called Taskforce 1000 (2016).

> ***…Over 60 percent of the children reviewed during Taskforce 1000 were placed with a non-Aboriginal carer, 41 per cent were placed away from their extended family and over 40 per cent of children with siblings were separated from their brother or sister. This Inquiry also found that almost half of the non-Aboriginal carers had not been provided with essential cultural awareness training. Support for kinship carers is seriously lacking and requires far greater resourcing, attention and effort to ensure that Aboriginal children have strong, capable and resillient carers…***
>
> ***(Commission for Children and Young People 2016, p. 11)***

The Taskforce 1000 process created a much stronger understanding of the critical role Aboriginal self-determination and culture play in healing trauma of the past and building resilience and capacity into the future. The process involved bringing the child protection system (government & non-government) together around each and every child so that there could be a greater understanding of the trauma, complexity and the challenges for Aboriginal children and families in order to create a sense of urgency for change.

The rationale for developing for culturally appropriate, culturally safe, and culturally informed interventions when working with Children from Aboriginal and Torres Strait Islander backgrounds is documented widely throughout literature and policy guidelines and frameworks aiming to address the issues of over-representation of Aboriginal and Torres Strait Islander children in care. The UN Convention on the Rights of the Child (1989) clearly states that an Aboriginal and Torres Strait Islander child 'shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language' (p. 9).

Raman et al. (2017), in their article which explores why taking culture seriously in out-of-home care is important, state that engagement and connection to one's culture is a significant factor in Aboriginal and Torres Strait Islander children's developmental health and well-being in out-of-home care. They argue that *'a trauma-informed and culturally embedded programme of therapy and support, individualised for each child, is essential for Aboriginal children in care'* (Raman et al., 2017, p. 900). This is because Aboriginal and Torres Strait Islander children in care who have strong cultural connections and knowledge develop a more grounded and centred sense of 'belonging' and identity. Culturally safe and informed practices and interventions are seen as not only key but also necessary. Culturally informed practice therefore moves beyond competence or even awareness – it is the deliberate deconstruction and reconstruction of the societal attitudes, and the development of policies that acknowledge, respect and enable child welfare agencies to practice effectively and safely in with different cultural contexts. The systematic neglect or misunderstanding of culturally safe approaches has implications on how Aboriginal children experience care in out-of-home situations.

Bamblett et al. (2014) emphasise the importance of culture by arguing that a cultural identity should not just be an add-on to the best interests of the child in care. A culturally informed practice is that which

> ***…completely understands [that]…denying cultural identity is detrimental to their attachment needs, their emotional development, their education and their health. Therapeutic residential care for Aboriginal children and young people must incorporate cultural knowledge and understandings of their holistic needs…***

This means that merely removing an aboriginal child from harm is not enough, and that spiritual and cultural safety should be considered because they are intrinsically linked to the overall wellbeing of Aboriginal and Torres Strait Islander children. William (1999) defined cultural safety as:

> ***…an environment which is spiritually, socially and emotionally safe, as well as physically safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, of learning together with dignity and truly listening (p. 213)…***

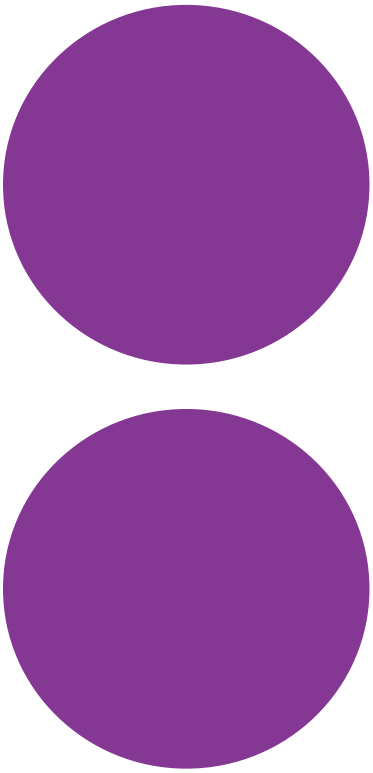
The Return to Country Framework developed by Victorian Aboriginal Child Care Agency (VACCA) suggests that an Aboriginal-informed perspective into the care of children is one that acknowledges:

- The child's relationship to their whole family not just to their parents.
- The child's relationship to their community, not just their family.
- The child's relationship to the land and the spirit beings which determine law and meaning (Victorian Aboriginal Child Care Agency).

This means that care for Aboriginal and Torres Strait Islander children needs to enable the cultural relationships to other Aboriginal and Torres Strait Islander people, to the land and to cultural norms and practices. This sense of cultural safety and respect has a direct link to Aboriginal and Torres Strait Islander children's emotional and physical safety while they are in care. Put simply, it is important and indeed necessary that *'Aboriginal children in care know where they are from and are taken to visit their 'country' to see, feel and experience their land and to meet their own community Elders and members'* (Bamblett et al., 2014, p.209).

The Stronger Safer Together practice resource by SNAICC stated clearly that effective practice recognises and adapts to the unique cultural practices and histories of the communities involved. To this end, they suggested that culturally informed, competent and safe practice recognises:

- The innate value and continuing strengths of Aboriginal and Torres Strait Islander cultures that have provided love, nurturance and care for children in Australia for tens of thousands of years,
- That many issues affecting Aboriginal and Torres Strait Islander families, including poverty, substance misuse and domestic violence, are connected to the legacy of intergenerational trauma caused by experiences of colonisation, including forced child removal. Responses must engage deeply with processes of individual and community healing, and
- That Aboriginal and Torres Strait Islander peoples have a wealth of cultural knowledge and connection that makes them best placed to lead and inform responses to the child and family welfare issues that are impacting their communities (Secretariat of National Aboriginal and Islander Child Care, 2016, p. 9).



Culturally appropriate interventions need to be trauma-informed. Atkinson et al. (2014, p. 290) argue that it is important to understand 'symptom as history'. This means that there needs to be a thorough understanding of past and present trauma that continues to affect Aboriginal and Torres Strait Islander families and communities. Atkinson et al. (2014, p. 289) adds that 'Through observation we can begin to consider the likelihood of trauma in an individual, family, community, or other grouping. Our capacity to listen to, and witness the human story without judgment is vital, linking what we hear and see to [our practice].' This trauma-informed knowledge enables us to practice without re-traumatising Aboriginal and Torres Strait Islander people.

In summary, Aboriginal agencies across Australia have been calling for responsive and safe practice for Aboriginal and Torres Strait Islander people where cultural dynamics and strengths are respected, acknowledged and incorporated into the delivery of child welfare services. Effective practice should always have a place for culture (Secretariat National Aboriginal and Islander Child Care (SNAICC), 2013). This review identified a number of promising policy and practice frameworks promoting culturally safe and strong Aboriginal and Torres Strait Islander Australian communities.

Progressing the National Framework for Protecting Australian Children

The National Framework for Protecting Australia's Children 2009–2020 (the National Framework) is a collaborative response to the wellbeing of Australia's children and young people, by the commonwealth, state and territory governments and the non-government sector, with the key message of 'Protecting Australia's children is everyone's business'. Six supporting outcomes were developed as part of this framework, with supporting outcome five relating specifically to Aboriginal and Torres Strait Islander families: 'Aboriginal and Torres Strait Islander children are supported and safe in their families and communities' (Commonwealth of Australia, 2009). Three strategies to meet this outcome were developed, namely: *'a) expanding access to Aboriginal and Torres Strait Islander mainstream services for families and children; b) promoting the development of safe and strong Aboriginal and Torres Strait Islander communities; and c) ensuring that Aboriginal and Torres Strait*

Islander children receive culturally appropriate protection and care' (Commonwealth of Australia, 2009, p. 29–30). The National Framework operates through a series of three-year action plans, with annual reports outlining the ongoing commitment and progress toward the framework's outcomes (Department of Social Services, 2018). The 2014–15 and 2015–16 Annual Report is the sixth and most current review of the National Framework. The key activities of relevant states and territories against the National Priority of Closing the Gap during this period (2014–2016) are detailed in the report (Department of Social Services, 2018).

A summary of progress made by each state and territory is presented below.

Victoria

Transitioning Aboriginal children to Aboriginal agencies: The Victorian Department of Health and Human Services, in collaboration with the Commission for Children and Young People and Aboriginal Community Controlled Organisations (ACCOs), has begun the process of transitioning the Secretary's legislative functions and powers for children on protection orders to ACCOs. This recognises the rights of Aboriginal and Torres Strait Islander people to self-determination, together with the importance of connection to family, community, culture and country. This is a significant move forward, giving the care and decision making of all Aboriginal and Torres Strait Islander children and young people on care order to ACCOs.

Cultural planning: The requirement of a cultural plan for all Aboriginal children living in out-of-home care is now embedded in state legislation, together with a revised cultural planning model. The model enabled the establishment of key advisor positions with ACCOs, together with an information portal where information can be shared with carers and professionals, to support cultural planning and connection.

Northern Territory

Department of Health's Aboriginal Cultural Security Policy and Framework: Development of the Aboriginal Cultural Security Framework and Health Special Measures Plan, aimed at training and developing the cultural capabilities of the health workforce.

A Share in the Future – Review of Aboriginal and Torres Strait Islander Education: 51 recommendations and a 10-year strategy to support the education of Aboriginal and Torres Strait Islander students, including attendance, literacy, numeracy and higher education pathways.

Remote Family Support Service: Established to provide holistic case management support to vulnerable remote families.

Social and emotional learning: 24 schools are participating in the inclusion of social and emotional wellbeing into their curriculum, guided by the needs of the community.

New South Wales

Improving out-of-home care for Aboriginal children and young people in NSW through co-design: 32 actions will be implemented over five years to improve out-of-home care for children and young people.

Aboriginal Cultural Inclusion Framework: This framework aims to reduce overrepresentation by embedding cultural inclusion into the Department of Family and Community Services.

Aboriginal community forum – Our Kids Our Way: Aboriginal community forum enabled lived experience to be shared and heard by government, resulting in 21 recommendations and a commitment to an independent review of cases involving Aboriginal children in out-of-home care.

Cultural Care Plan for all Aboriginal children and young people in NSW in care: With a focus on culture, family and community, each plan is focused on the child placement principle of connection and consultation.

Grandmothers Against Removal: Collaborative response to the participation of local Aboriginal communities in decision making as it relates to child protection.

Aboriginal Child and Family Centres: Funding commitment to early childhood care and education for Aboriginal children.

Western Australia

Aboriginal Services and Practice Framework 2016–18: As part of the Department for Child Protection and Family Support review, the framework highlights the essence of partnership with Aboriginal communities when developing and implementing child protection services. It sets parameters for policy, practice, workforce planning and funding to meet the needs of Aboriginal communities, children and families.

South Australia

Kurlana Tangkuinya 'New Dreams': Establishment of a holistic case management service for Aboriginal women and children who are at risk of homelessness and experiencing family violence, providing safe accommodation and support with employment, education and training.

Walk Along initiative: Department for Education and Child Development initiative to support children, young people and their families moving to Adelaide from Anangu Pitjantjatjara Yankunytjatjara (APY) and Maralinga Tjarutja Lands. The Walk Along team operates as a mobile outreach team, helping families to access culturally appropriate care, education and crisis services, together with offering support to schools.

Queensland

Family Wellbeing Services: Five years of funding is committed to the establishment of community run family wellbeing services. This is the result of a joint action plan with the community to address the disproportionate representation of Aboriginal and Torres Strait Islander families in the child protection system and also improve life outcomes.

Aboriginal and Torres Strait Islander Service Reform Project: Collaborative response between government and the community to consider more effective ways of engaging with and meeting the needs of the Aboriginal and Torres Strait Islander community with the aim of reducing over-representation.

Child and Family Connect: Provision of an alternate pathway of support and advice to families, inclusive of short-term intervention.

In partnership with Family Matters (SNAICC), the Queensland Government is the first jurisdiction to develop a shared strategy to meet the aim of eliminating the overrepresentation of Aboriginal and Torres Strait Islander children in out-of-home care by 2040.

Our way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037, together with Changing tracks: An action plan for Aboriginal and Torres Strait Islander children and families 2017–2019, demonstrates a 20-year commitment to working collaboratively to closing the gap and eliminating over-representation (Department Research Report: Evidence Base for Therapeutic Group Care 47 of Communities, Child Safety and Disability Services, 2017). With five key priority areas for the next three years, policy and practice is focused on providing early support

to young women under 25 and their partners; increasing access to and support for children aged two to five years; support for children with complex needs; focused support to children in out-of-home care; and support to young people aged 15 to 21 leaving care (Department of Communities, Child Safety and Disability Services, 2017).

Tasmania

Aboriginal Centre: Funding provided by the state government to the Tasmanian Aboriginal Centre to update and distribute two resource booklets: *'palawa kids can say no'* and *'family violence is not ok! for palawa kids'.*

Promising Australian Aboriginal and Torres Strait Islander Policy and Practice Frameworks

Whist an understanding of context is critical, we also acknowledge that there are a number of promising policy frameworks and practices in Australia that have been documented in literature; practices that promote Aboriginal and Torres Strait Islander-led frameworks, such as 'Dadirri', which is an Aboriginal concept that means deep and respectful listening – the kind that builds community and healing though listening with 'intent, heart and spirit' (Atkinson, 2002; Couzens, 2017, p. 9), healing circles and yarning circles (Atkinson, 1994; The Healing Foundation, 2017). We now document these promising policy and practice frameworks below.

The Bringing Them Home report, identified earlier, was considered a significant milestone for Australia's Stolen Generations, and the Aboriginal and Torres Strait Islander community more broadly (Healing Foundation, 2017). The report outlined five key principles to guide government responses to those children forcibly removed from their families, specifically self-determination, non-discrimination, cultural renewal, coherent policy base and the provision of adequate resources (Human Rights and Equal Opportunity Commission (HREOC), 1997). These principles, together with the report's findings, guided the 54 recommendations made by the Commission (HREOC, 1997). In response, a number of action plans have been developed, legal and policy frameworks designed and implemented, and reviews commissioned. The report is an acknowledgment of Australia's past, setting the foundation for healing, upholding rights, meeting needs and holding policy makers to account.

The Aboriginal and Torres Strait Islander Child Placement Principle ('the Principle') was developed over 30 years ago as a result of a grassroots movement by key Aboriginal and Torres Strait Islander agencies, who understood the devastating impacts of forced removal on individuals, families and communities (Australian Institute of Family Studies, 2015). The *Bringing Them Home* report gave a voice to the Stolen Generations, highlighting the imperative of governments to redress wrongs of the past and develop policies and practices that ensure participation and connection to family, community and culture. Over time, the Principal has been embedded into legislation and developed into policy, aiming to safeguard and protect the rights of Aboriginal children and young people, their families and communities, and reduce over-representation in the child protection system. The Principle states that *'each Aboriginal and Torres Strait Islander child has the right to be brought up within their own family and community [and that] the participation of Aboriginal and*

Torres Strait Islander community representatives, external to the intervention, placement and care, and judicial decision-making processes [be sought]' (Arney et al., 2015). If children are unable to remain safely in the care of their family, the Principle gives guidance to placement priorities.

The Closing the Gap Framework is of significance in the discourse surrounding Aboriginal and Torres Strait Islander in care. It was developed as a National Priority as part of the National Framework's Second Action Plan 2012–2015, and against supporting outcome five. This priority states: *'Closing the gap – aiming to ensure that Aboriginal and Torres Strait Islander families and communities are in a position to provide their children with the safe and supportive environments they need to reach their full potential'* (Department of Social Services, 2018, p. 83). To support progress against this priority, the Third Action Plan 2015– 2018 has a focus on early intervention and prevention, together with Aboriginal and Torres Strait Islander children, families and communities, due to their disproportionate involvement with the child protection services (Department of Social Services, 2015). The Aboriginal and Torres Strait Islander Working Group has been established and chaired by SNAICC, overseeing that the implementation of the plan and ensuring it remains focused on achieving outcomes for Aboriginal and Torres Strait Islander families and children (Department of Social Services, 2018). This plan provides a commitment to upholding, expanding and actioning the Aboriginal and Torres Strait Islander Child Placement Principle, ensuring connection to country, family and community, with a focus on prevention, participation, partnership, placement and connection (Department of Social Services, 2015). The actions and recommendations, made as part of the *Pathways to safety and wellbeing for Aboriginal and Torres Strait Islander children* report (SNAICC, 2015), are acknowledged as guiding this third action plan.

Pathways to safety and wellbeing for Aboriginal and Torres Strait Islander children is a policy direction which details four pathways for change and 10 actions to achieve this change (SNAICC, 2015), with the aim of informing policy and practice development, and enhancing the overall wellbeing and safety of Aboriginal and Torres Strait Islander children. The four pathways to safety and wellbeing are: 1) supporting families and communities to stay together; 2) Aboriginal and Torres Strait Islander participation; 3) trauma and healing informed approaches; and 4) systems accountability to Aboriginal and Torres Strait Islander priorities (SNAICC, 2015, p. 8). These pathways underpin a national campaign led by *SNAICC – Family Matters: Strong Communities. Strong Culture. Stronger children.* This campaign has a strategic alliance of over 150 individuals and organisations, aiming to 'eliminate the over-representation of Aboriginal and Torres Strait Islander children in out-ofhome care by 2040' (SNAICC, 2016, p. 5). It is underpinned by six key principles, which each alliance commits to, namely:

> ***…applying a child focused approach; ensuring that Aboriginal and Torres Strait Islander people and organisations participate in and have control over decisions that affect their children; protecting Aboriginal and Torres Strait Islander children's right to live in culture; pursuing evidence-based responses; supporting, healing and strengthening families; and challenging systemic racism and inequities (SNAICC, p. 5, 2016) ...***

Promising practice and practice frameworks for Aboriginal and Torres Strait Islander children, young people, families and communities

The literature identified above clearly establishes that removal from country, the forced removal of Aboriginal children from their families, institutionalisation and abuse has caused significant trauma to Aboriginal children, families and communities, with intergenerational trauma part of contemporary society (Human Rights and Equal Opportunity Commission, 2007; SNAICC, 2015; Healing Foundation; 2017). Although trauma research in relation to Aboriginal children, their families and communities is in its infancy (Atkinson, 2013), promising practice is being delivered and frameworks developed that focus on healing and recovery. Here we highlight some of these promising practices.

Pathways to safety and wellbeing for Aboriginal and Torres Strait Islander children. This details trauma and healing informed approaches as a pathway to wellbeing and safety (SNIACC, 2015). Also guiding the National Framework's Third Action Plan 2015–2018, this pathway identifies the importance of Aboriginal and Torres Strait Islander communities developing and delivering their own healing approaches, research being undertaken to guide practice, and workforce development strategies to embed trauma and healing practices within service delivery (SNAICC, 2015).

Atkinson (2013) discusses the importance of developing trauma-informed services to support Aboriginal and Torres Strait Islander people. She further explains that within these services, knowledge of trauma must set the foundation for service delivery, with core values guiding intervention and support (Atkinson, 2013). In addition, when providing trauma informed care, specific cultural factors must be considered, being most powerful when led and developed by Aboriginal and Torres Strait Islander-specific approaches (Atkinson, 2015).

Whilst acknowledging the need for further research to enhance understanding and guide trauma recovery practice with Aboriginal and Torres Strait Islander Australians, a number of innovative practice examples are identified within the literature. The following is a summary of these:

Australian Aboriginal and Torres Strait Islander Health *Infonet* Healing portal

The Healing portal is an online hub aimed at sharing research and best practice initiatives to support the collaborative development of healing opportunities in communities. Information specific to the Stolen Generation, children and young people, men, women and community is detailed (Department of Health, nd)

Healing Foundation

Established in 2009, the Healing Foundation is a statutory body receiving federal funding and reporting to the Department of the Prime Minister and Cabinet. With a focus on providing a framework for and voice to the healing issues for Aboriginal and Torres Strait Islander people, the organisation has provided funding to approximately 175 community based healing projects (Healing Foundation, 2018). As it relates to children and young people, projects include:

- **Aboriginal and Islander Independent School, Murri School, Qld:** Since 2012, the healing program aims to address intergenerational trauma by providing a holistic and collaborative response to the social and emotional wellbeing of students. The project supports 'therapeutic intervention, service coordination, family case work, family camps, cultural and group activates

and (re)connection with educational and supporting activities' (The Healing Foundation, p. ii, 2017). Trauma-informed teachers, family support workers, allied health professionals and psychologists provide a culturally supportive environment for children and their families.

- **Brewarrina Central School and Bourke High School, NSW:** Via a partnership between the community and the school, healing pathways will be developed for Aboriginal children, their families and the community. The two core elements of the program are: weekly yarning circles led by the trained, school-based Aboriginal healing team, focused on SELF – safety, emotional management, loss and future (Healing Foundation, 2018), and young people and family camps, aimed at strengthening confidence, capacity and relationships (Healing Foundation, 2018a).
- **Healing Centres:** Community owned and operated spaces to support healing for Aboriginal and Torres Strait Islander people; activities are developed and implemented in response to local community need. An example is Healing Waters, Aboriginal and Torres Strait Islander Counselling and Wellbeing Service in the Townsville community (Qld), built on social justice, self-determination and cultural healing practices (Healing Foundation, 2018c).
- **Healing Forums:** Aimed at supporting communities to understand and identify the healing needs of their community, Healing Forums also provide an opportunity for Aboriginal and Torres Strait Islander people to inform, build partnerships with and influence government and non-government policy, practice and funding in their community (Healing Foundation, 2018b).
- **Women's healing: Coota Girls Aboriginal Corporation:** Focused on collective healing through providing a space for women to gather, share their stories, support each other and heal. The Healing Foundation, in their support of healing with women and girls, acknowledge their central role in developing local solutions to issues of abuse and violence, together with the pivotal role of women in restoring balance and harmony (Healing Foundation, 2018d).
- **Men's healing: Ngukrr Men's Healing Program, NT:** With over 150 men participating regularly in healing programs, Healing Foundation reports positive impacts on families and communities (2018e). With a focus on strengthening wellbeing, workshops are designed and delivered to meet local needs, with cultural values and identity strengthened through activities such as artefact production, song, dance, camping and yarning (Healing Foundation, 2018e).

Australian Family Wellbeing Programs

The Family Wellbeing empowerment program (FWB) is a well-established Australian program developed in the early 1990s by the Aboriginal Education Development Branch of the South Australian Department of Education, Training and Employment (Whiteside, Tsey, Cadet-Janes & McCalman, 2014). The program was developed in response to a growing awareness that the process of colonisation had 'propelled Aboriginal Australians away from their collective tribal traditions into a competitive and individualised Western society, resulting in the breakdown of extended families and their clans and their traditions and customs' (Whiteside et al., 2014, p. 2). It was developed based on a premise that individuals, organisations and communities can be empowered to gain control over their lives, and that their health and wellbeing can be enhanced as a result. By 2012, the program had been delivered to over 3,300 people in 56 sites across Australia with well documented outcomes, and had been recognised as an 'exemplar' by a systematic review undertaken by Closing the Gap (Dudgeon, in Whiteside et al., 2014).

Initially delivered with a focus on the wellbeing and empowerment of adults, the FWB program was recently piloted in the Central Coast of NSW with a group of young Aboriginal men (Whiteside, Klieve, Millgate, Webb, Gabriel, McPherson & Tsey, 2016). Two male Aboriginal Community workers

delivered the structured program to a group of 30 Aboriginal young men between the ages of 16 and 25 years, who were referred to the program having been identified as at risk of 'self-harm' or currently incarcerated in a juvenile justice facility. Each of the young men were reported to have experienced a range of challenges and disadvantage, including violence, addiction and mental illness, prior to program commencement. At the completion of the flexible, five-stage FWB program, a range of measures assessed progress in relation to participants' attitudes to work and further learning, coping and mental health, relationships and physical health. The results of this pilot study were promising, with an overall result indicating that 'the quantitative and qualitative study results combine to suggest that FWB has the capacity to engage young Aboriginal men and make a marked contribution to their social and emotional wellbeing' (Whiteside et al., 2016, p. 250). In a similar but different pilot, the Family Wellbeing program has also been adapted to meet the needs of Aboriginal and Torres Strait Islander schoolchildren living in remote communities (Tsey, Whiteside, Deemal, Gibson, Wilson, Santhanam & Haswell- Elkins, 2004).

Yorgum child and family counselling service

Atkinson (2013) identifies examples of cultural approaches to trauma-specific care for children. These approaches recognise the need to develop Aboriginal and Torres Strait Islander-specific models of practice which can deliver trauma-specific, culturally safe healing activities for Aboriginal and Torres Strait Islander children. Yorgum is presented as a promising example of therapeutic work within an Aboriginal child and family counselling service based in Western Australia. Services offered include 'yarning therapy', based on the principle that telling the story is part of the therapeutic process (Atkins, 2013, p. 11)

Australian We Al-Li Programs

We Al-Li (the Woppaburra terms for fire and water) is another example of a communitybased response to the trauma experienced by some Aboriginal and Torres Strait Islander Australians and the need, as a consequence, to developing healing practices (Atkinson, 2013). A series of workshops have been developed for practitioners working in the field of trauma, with one focusing on work with children. Foundational learning in this workshop is to understand child development and trauma and the need for cultural safety. On the basis of this deep understanding, skills are developed to promote spiritual and cultural growth and identity (Atkinson, 2013, p. 12). Evaluations are promising, indicating that participants in workshops 'identified the strongest tools as: story, art, music, theatre, dance, always placing the trauma stories of people and place as the centre piece of our work. …These stories were not just about individuals but linked social groups across history and country' (Atkinson, cited in Atkinson 2013). These healing circles, which are provided through culturally appropriate forms of expressions, are a great opportunity to support Aboriginal and Torres Strait Islander families to connect to different aspects of culture and country.

What do we know about the needs of children and young people with diverse backgrounds in care?

It is now well accepted in research and practice that children and young people in out-of-home care are some of the most vulnerable and disadvantaged groups in society (Collin- Vézina, Coleman, Milne, Sell & Daigneault, 2011; Gatwiri et al., 2018; McPherson et al., 2018). This vulnerability increases for children with other complex needs, or those experiencing 'double jeopardy' due to their minoritised backgrounds (Cross, 1989; deFinney, Mackenzie, Loiselle, & Saraceno, 2011; Trocmé, Knoke & Blackstock, 2004).

In their dissertation, Dean (2012, p. 2) showed that:

> ***…Minoritised children and youth, including those who are LGBTQ, nongender conforming,… have [dis]abilities or special needs, have poor/low socio economic status (SES) and/or minority/immigrant/refugee status are overrepresented as clients within the child welfare and residential care systems….***

We use the terminology 'minoritised' following Mckenzie's (2012, p.2) argument that

> ***…Minoritised groups are positioned as outsiders to dominant norms and consequently seen to fall short of the standards of the dominant group, and are seen as "less than" or "other". Minoritisation [therefore] stands in contrast to adjectives such as minority, marginal and at risk because of its focus on the process of categorisation and exclusion of the Other, based on differences of race, gender, sexuality, ethnicity, culture or ability (among others)….***

It is also now clearly established that there are systemic issues, challenges and complexities that facilitate the reproduction of the over-representation of minoritised children in care. DeFinney et al. (2011) argue that it is necessary to 'problematize the systemic minoritization of certain groups of children and youth to understand their over-representation in residential care' (p. 362). Children of minoritised backgrounds, such as those with disabilities, those who are queer, those from immigrant or refugee backgrounds, unaccompanied minors and those from culturally and linguistically diverse (CALD) backgrounds have extra challenges in care. Although the scope of literature in this area is limited, we do know, as evidence suggests, that children and young people's experiences are complicated by other compounding intersections such as race, gender, disability, ethnicity, religion, immigrant status, sexual orientation and class (Dean, 2012; Lavergne, Dufour, Trocmé, & Larrivée, 2008).

For example, children and young people from CALD backgrounds often experience unique challenges such as a sense of displacement from their culture as well as discrimination while in care. Similarly, a higher proportion of LGBTQ youth placed in care experience significant and complex challenges as compared to their heterosexual counterparts (Hafford Letchfield, Simpson, Willis & Almack, 2018) . Cook and Cohen (2018, p. 3) say that 'LGBTQ youth who are youth of colour, undocumented immigrants, from low income families, living with disabilities, or at the intersection of many or all of these identities, inequities and discrimination in society and in care… are disproportionately represented in out-of-home care systems.' Some literature has shown that experiences of residential care produce negative outcomes (see for example, Carr, Duff & Craddock, 2018; Knorth, Harder, Zandberg & Kendrick, 2008). This is more so for children and young people who are from backgrounds that are minoritised and marginalised.

Multiple jeopardy

The phrase 'multiple jeopardy' originates from 'double jeopardy', and is commonly used in sociological terms to refer to the additional and multiple obstacles that individuals face when they experience compounding disadvantages due to their unique situations. This is now what is commonly referred to as 'intersectionality' – which considers how various personal and structural disadvantages, such as class, race, sexual orientation, age, religion, disability and gender are interwoven to produce a more complex experience of oppression. Children who are in care are already significantly disadvantaged; however, additional variables such as gender, cultural identity, sexual orientation, age and disability might complicate their experiences of care.

Children with disabilities

The majority of the studies focused on intellectual disabilities (Alba et al., 2018; Brkic et al., 2014; Merrick et al., 2008; Sainero et al., 2013; Wissink et al., 2018). Other forms of disabilities, such as sensory disabilities, psychiatric disabilities, physical disabilities and chronic & neurological disabilities, are understudied in the context of out-of-home care experiences.

Sainero et al. (2013, p. 1394) notes that *'despite the high numbers of children with disability in [residential] care, there is very little research describing their specific situation, their characteristics, and the type of care they receive.'* Considering their greater vulnerability, there is an absolute necessity to take into account the unique needs of children and young people with disabilities when they are placed in residential care.

Children with disabilities face additional barriers compared to other children in care because they have more complex needs (Mendes & Snow, 2014). Although the literature about the prevalence of children and young people with disability in OOHC is still relatively scanty, the literature that is available so far shows that children and young people with disabilities experience abuse and neglect at a higher rate than those without disabilities (Hibbard, Desch & Committee on Child Abuse and Neglect, 2007; Kendall-Tackett, Lyon, Taliaferro, & Little, 2005; Lightfoot, Hill, & LaLiberte, 2011; Lightfoot & LaLiberte, 2006; Sullivan & Knutson, 1998, 2000). There is a clear gap in knowledge showing the prevalence of children with disabilities in the child welfare system, their characteristics and their unique needs. This poses a challenge for the provision of the appropriate support services.

The complexity of the needs of children with disability is compounded by needs relating to their *'physical, intellectual, sensory, communication and/or psychiatric impairments... [which puts them] at a high risk of bullying, abuse and exploitation'* (Mendes & Snow, 2014, p. 115). Mendes & Snow (2014) continue by stating that children and young people with disabilities in care experience additional attitudinal barriers as well environmental barriers which complicate their physical movements, and their access to services and resources. These negative attitudes promote behaviours that 'perpetuate the acceptability of ridicule, harassment or physical harm' towards children with disabilities and allows this behaviour to go largely unchallenged (Mepham, 2010, p. 23). Children with disabilities have a right to feel safe. But children's disabilities make them 'easy' targets for bullying because they are seen as 'different' or 'helpless' by other children and young people in residential care centres (Mepham, 2010).

The research by Sainero et al. (2013) shows that children and young people with disability

> ***…undergo greater instability in their itinerary through [residential] care, with more interruptions and placement changes. [They also tend] to remain in the system for longer than their non-disabled peers' due to challenges in finding suitable foster homes or placements (p. 1394)…***

Children and young people in residential care are also likely to exhibit more challenges with their academic performance, more mental health issues, and more behavioural related challenges including disruptive and aggressive behaviours. Alba et al. (2018) noted that children and young people with disabilities are also twice more likely to suffer clinical depression than their peers without disabilities. Dixon (2008) shows that children and young people with disabilities in care are over-represented among those who are not participating in education and training. The majority are considered 'problematic' and difficult to deal with. This poses extra challenges where the training and education to cope with challenging behaviour is often limited. Casey et al. (2008, p. 910) adds that:

> ***…Children [with disabilities] are a particularly vulnerable group in that they exhibit one or more disorders related to sensory (e.g., hearing impairment), physical, developmental (e.g., emotional disturbance) and neurological functioning (e.g., attention deficit hyperactivity disorder), affecting their progress in the [residential] home, school, and community….***

LGBTQ children and young people

Unsurprisingly, sexual orientation and gender identity of young people entering care is not always considered as an issue. This is problematic when there is overwhelming research that shows that that LGBTQ youth in care are at a greater risk of re-experiencing trauma through homophobic or transphobic stigma, discrimination and bullying, leading to increased significant mental health difficulties. LGBTQ youth in care are likely to experience a 'multiple jeopardy' with intersecting disadvantages of their adverse childhood experiences that bring them into care compounding with the negative experiences of being queer in care.

From this review, studies show that LGBTQ youth are at more risk of experiencing child maltreatment, abuse and neglect compared to youth who are heterosexual (Love, 2014; McCormick et al., 2017; Scannapieco et al., 2018). Scannapieco et al. (2018) shows that LGBTQ youth are more likely 'to be rejected by their families, are at higher risk of suicide, [have] higher levels of depression and are more likely to use substances' (p. 39). There are other unique but numerous challenges and barriers that are experienced by LGBTQ youth in the care system. These challenges have different layers and arrays of complexities. The child welfare system is traditionally heteronormative, and only recently the needs of LGBTQ youth have started being considered. The heteronormativity of the

care system produces unintended harm and damage to LGBTQ youth in care. This is a matter for concern when research suggests that both LGBTQ young people and young people in care are at risk of stigma, discrimination, bullying and mental health difficulties. There is the potential, therefore, for LGBTQ young people in care to face a 'double jeopardy'.

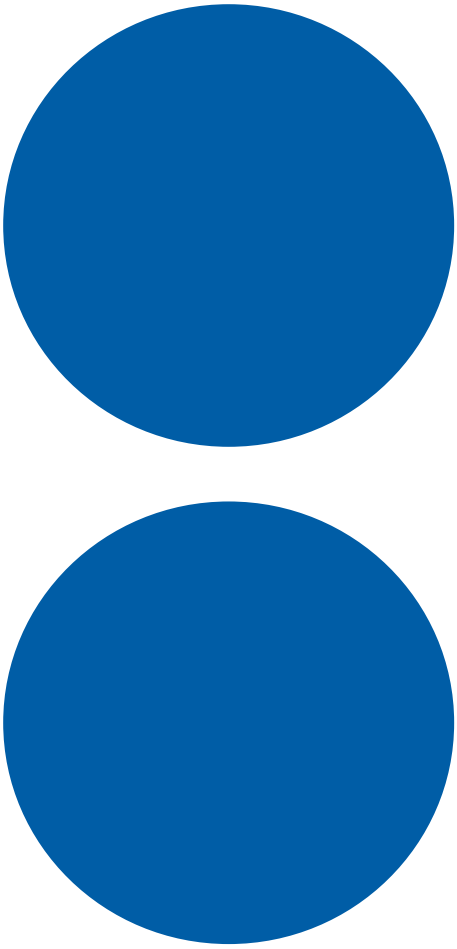
McCormick et al. (2017) states that children and young people who identify as Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) are largely over-represented in the child welfare system. For the purposes of this report, they will be referred to as 'queer' – an accepted term in both literature and in community. Despite their over-representation in care, there is a reluctance to acknowledge that both the presence and unique needs of LGBTQ youth in care. McCormick et al. (2017) adds that 'the child welfare system's inability and unwillingness to acknowledge the presence of LGBTQ youth has largely been responsible for many of the problems that currently exist (p. 28). LGBTQ youth in care often report feeling pressured to hide their sexual orientation, and to remain silent about what they need. This pressure to remain invisible while in care leads to institutional silence about the needs of LGBTQ youth in care. Speaking about the Child welfare system in the United States, Scannapieco et al. (2018) state that one of the ways in which LGBTQ children and young people remain invisible in the system is that their sexual orientation or gender identities/ expression are not officially recorded upon entry in care.

McCormick et al. (2017) further add that the lived experiences of LGBTQ youth in care are often overlooked – even though this group of young people in care experience multiple challenges and difficulties as they navigate the child welfare system. These challenges include experiences of isolation, marginalisation, discrimination and an overall lack of acceptance and stability. Many LGBTQ youth in care also experience ongoing harassment, violence, teasing, ridicule, bullying, name-calling and abuse related to their sexuality and sexual orientation. Sometimes the harassment and/or the lack of acceptance is from peers and at other times it is reported to be from staff and caretakers. McCormick et al. (2017) state that many LGBTQ youth report that they are treated significantly differently when their sexual orientation or gender identity becomes public knowledge.

LGBTQ youth report 'being pressured to see therapists or enter programs aimed at changing a child's sexual orientation, despite the overwhelming evidence noting the negative psychological and social consequences of reparative and conversion' (McCormick et al. 2017 In terms of disciplining incidents, McCormick et al. (2017) further add that *'it is common for LGBTQ youth in group home settings to be isolated to their own bedroom or to their own wing of the house due to fears of placing them with youth of the same sex'* (p. 30). Sometimes, they are punished for engaging in age-appropriate, consensual, same-sex relationships while heterosexual youth in care are encouraged to engage in appropriate consensual relationships without any punishment. Many others report that *'caretakers are often more inclined to blame LGBTQ youth for their mistreatment than they are to intervene and provide consequences to the perpetrator.'* This means that many LGBTQ youth in care do not feel safe in residential care when they do not have LGBTQ friendly services and care plans.

In-terms of the mental health of LGBTQ youth, Scannapieco et al. (2018) say there is a higher prevalence of suicidality among LGBTQ youth. They found that LGBTQ youth in care are more likely to attempt suicide, have depression and experience gender identity-related problems when compared to heterosexual youth in child welfare. Put simply, if the needs of LGBTQ youth are not adequately identified, their challenges in the care system will continue to be overlooked and ignored. This may have implications of their mental health, including increased suicides and suicide ideations.

Unaccompanied children



Unaccompanied (refugee) children face challenges when entering a host country. Unaccompanied minors are 'vulnerable' children who need specialised care and attention. As record numbers of unaccompanied refugees enter Western countries, child welfare agencies and non-governmental organisations tasked with keeping children safe are struggling to keep up with numbers and with the demands of their needs. Arriving and attempting to settle in a new host country can have tremendous challenges, especially for unaccompanied minors. In this systematic scoping review, only one article discussed the plight of unaccompanied children living in transitional houses – in Sweden (Malmsten, 2014). The children risk their lives and often have no knowledge of the whereabouts of their family, relatives and friends. Malmsten (2014) says that unaccompanied minors who have passed through countries in southern Europe to get to Sweden cannot apply for asylum and are often returned to the country in which they first resided. When they are awaiting their 'return' (deportation), the children suffer psychologically, fall seriously ill and often attempt suicide. However, as Malmsten (2014) reports, the unaccompanied children are often accused of being attention seekers, or putting on a show, or manipulating their own sickness in order to get asylum.

What do children and young people from diverse backgrounds need?

Particular attention needs to be paid to children and young people from diverse backgrounds as they enter child welfare systems across the world. The child protection system needs to be responsive to the diverse needs of Aboriginal children, culturally and linguistically diverse communities, children with disabilities, children in remote areas, and children from LGBTQ communities. Children from diverse backgrounds, while they have similar needs of care to other children and young people in care, also experience a heightened need for safety, acceptance and belonging.

In summary, there was scant literature exploring the needs of minoritised children in care. Not much literature has explored the unique needs of children with disabilities, children and young people of different gender identities and sexual orientations, children from culturally and linguistically diverse communities, children from refugee backgrounds or those seeking asylum. An unintended finding in this review revealed that most residential care across the world is centred on Anglo-centric values that are monolithic. Care programs are developed with the 'one-size-fits-all' approach as Alegria et al. (2010) suggest. This approach does not work for children and young people whose experiences exists outside of the standard white, heteronormative, able-bodied spectrum.

The limited research involving children with diverse needs concludes that, despite an emphasis on person-centred care, ingrained homophobia, transphobia, racism, cultural ignorance, ableism, and partial intolerance towards children with more complex needs makes it more difficult for children from minoritised backgrounds to truly feel safe and settled in care.

Conclusion

> ***…We are outraged by the discrimination still embedded in the system. And we despair that we are not being heard. (Secretariat National Aboriginal and Islander Child Care (SNAICC), 2015)…***

To conclude Part One of this report, we highlight the importance of using Indigenous-led frameworks, which have been reported to be useful in the efforts to mitigate the current issues that affect Aboriginal and Torres Islander children in care. Numerous research studies which have highlighted the collective and composite factors that have led to the current over-representation of Aboriginal and Torres Strait Islander children and other minoritised children in out-of-home care have consistently recommended culturally led and structural solutions.

A key message from literature, and in particular from Aboriginal and Torres Strait Islander led organisations in Australia such as SNAICC, is that efforts that do not seek to address systemic issues of colonisation, marginalisation, racism and structural disadvantage, and do not promote connection to culture and country, only fall short of any optimum results, and instead may contribute to reproducing disadvantage and inequality for the most vulnerable children placed in care. This means that emerging frameworks and policies need to consistently review and reflect on their practice to ensure that Aboriginal and Torres Islander children, and minoritised children, receive the best and most relevant support while in care.

Part Two: International and Australian Literature Reporting on Therapeutic Approaches to Care

In this section we present an overview of the therapeutic models of group care that were identified by this review as appropriate for inclusion. Eighteen distinct models of therapeutic group care were identified, and four practice approaches, which had been adapted for group care implementation, met the criteria for inclusion. A brief overview of each approach follows below, including identification of the theory of change, whether explicitly documented (or implicit), and the available evidence of evaluation or research outcomes. For the purpose of the review we have adopted the following definition of 'theory of change':

> ***…Documentation outlining how the core components of an intervention (inputs) bring about changes in staff behaviour and organisational processes or culture (outputs) and why and how these changes are thought to benefit children and young people (MacDonald & Millen, 2012, p. i)…***

1. CARE – Children and Residential Experiences

Overview

The Children and Residential Experiences (CARE) model is described as a multi-level program that involves all levels of an organisation in its implementation (Holden, Izzo, Nunno, Smith, Endres, Holden & Kuhn, 2010). Developed in 2005 at Cornell University in the USA, the CARE model seeks to translate theory and research into day-to-day practice which will enhance the quality of care experienced by children (Holden et al., 2010). The model has a focus on organisational leadership and change whilst promoting consistency across staffing groups in the way in which children's needs are identified and responded to. CARE draws on attachment and trauma theory and seeks to offer 'healing experiences' in order to assist children to overcome the impact of early trauma (Holden et al., 2010).

Core Components of the Model

The model is organised around six core principles, which focus on organisational climate and direct practice, as follows:

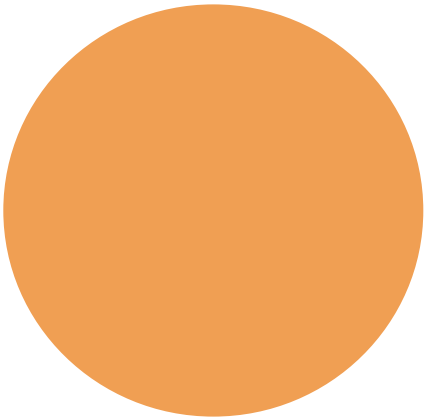
1. **It is developmentally focused, striving to enhance the child's opportunity for normative development.**
2. **It has a focus on family involvement, enhancing children's connection to their family relationships and as a consequence building children's cultural, cultural and ethnic identity.**
3. **The therapeutic milieu is relationship-based, in that children are offered opportunities to trust, experience safety and to form meaningful attachments.**
4. **There is a focus on building the competence of children to face life challenges and to develop new skills.**
5. **The organisational and care environment are trauma-informed, with a culture of safety and nonviolence.**
6. **There is an ecological orientation which recognises that children are in constant, dynamic interactions with their environment**

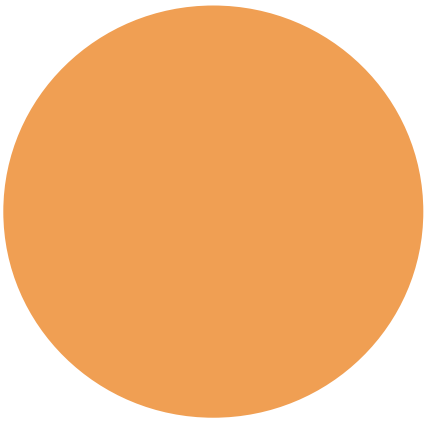
   (Holden et al., 2010).

Theory of Change

A clearly specified theory of change is premised on an assumption that children's wellbeing will be enhanced if staff at all levels within the organisation practice in a manner that is consistent which values children's best interests. All staff are intensively trained in the six core principles which have been derived from relevant research, and all staff contribute to a cohesive system of care. The theory of change suggests that enhanced staff–client relationships will contribute to improved social and emotional wellbeing for children.

Evaluation or research evidence





Early evaluations of initial implementation of CARE focused on participant reactions to the initial training programs, including intent to change. Early results appeared to be limited but promising (Holden et al., 2010). More recently, a multi-site study of CARE implementation in the USA (Holdren & Izzo, 2016) identified the following research questions:

1. To what extent does implementing CARE at residential childcare agencies lead to fewer serious behavioural incidents?
2. To what extent does CARE implementation lead to improved relationship quality between youth and direct care providers?

Two cohorts of agencies were identified for investigation, with the first cohort beginning CARE training and implementation immediately and the second cohort waiting about 12 months to commence CARE. Behavioural incident data was collected from all agencies using an interrupted time design (Shadish, Cook & Campbell, 2002), and relationships between children and carers were assessed using structured survey tools administered at 12-month intervals over 3 years.

Studies found that agencies implementing CARE led to 'significant declines for three important types of behavioural incidents (aggression toward staff, property damage and running away). The relationships between young people and staff showed improvement whilst CARE was being implemented, and continued to improve over the three years.

2. The Sanctuary Model

Overview

The Sanctuary Model (Bloom, 1997) was developed in the USA, and in the past two decades has been implemented in a number of countries, including some states and territories within Australia, via a certification process overseen by the model's architects (Leigh-Smith & Toth, 2014). Initially developed as a response to adult psychiatric institutional care, as a system-wide approach to promoting a healing and positive group climate at all levels of an organisation, to ameliorate the impact of trauma. Sandra Bloom's work was initially developed in the context of her analysis that the organisations that were designed to help vulnerable people could themselves be a source of trauma – described as 'factories of abuse and neglect' (Bloom & Farragher 2011, p. 4).

Core Components of the Model

Central to the Sanctuary Model is the development of a Therapeutic Community, with an emphasis on the power of living and learning in this environment to promote healing (Rivard, McCorkle, Duncan, Pasquale, Bloom & Abramovtz, 2004). The core components of the Sanctuary Model rest within what is described as a trauma recovery framework, based on an assumption that children in group care settings have been exposed to a range of adverse and traumatic experiences. The model involves staff members at all levels of the organisation engaging in an explicitly shared vision and subscription to a common set of Sanctuary Principles.

THESE INCLUDE:

- **Commitment to nonviolence**
- **Commitment to Emotional Intelligence**
- **Commitment to Social Learning**
- **Commitment to Open Communication**
- **Commitment to Democracy**
- **Commitment to Social Responsibility**
- **Commitment to Growth and Change**

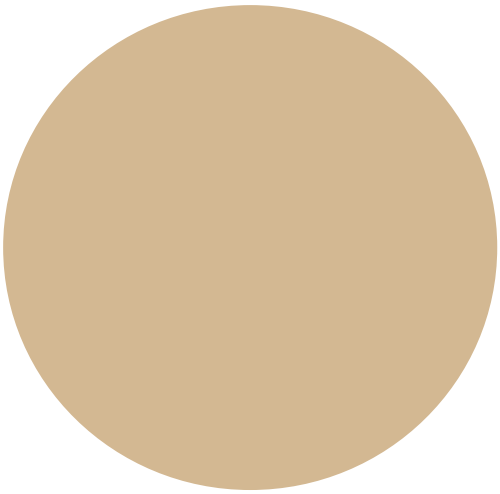
(Bloom & Farragher, 2011, p. 360).

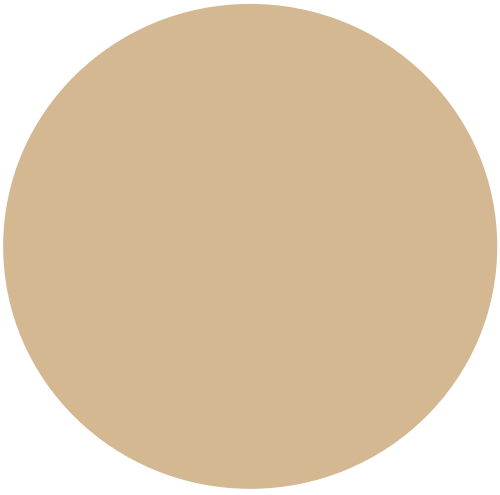
These commitments form the basis of an organisational environment that is conducive to healing. The practice framework is described as a cognitive behavioural therapeutic approach, and is summarised in the acronym S.E.L.F., which incorporates the four domains of safety, emotional management, loss and future. The S.E.L.F. framework is used by staff and clients as a means of communicating in accessible language that enables young people to identify and articulate their own recovery processes. This framework forms the basis of a practice tool kit which, rather than prescribing a manualised approach to treatment, offers a suite of skills to enhance practice. Staff meet as a community, in teams and in psychoeducational groups with young people to continuously operationalise their commitment to the seven core Sanctuary Principles.

Theory of Change

A theory of change is not specifically articulated by the authors of the Sanctuary Model. Inherent in the Sanctuary Model documentation, however, are assumptions that there is a shared commitment to the seven principles, and a shared and developing knowledge base in relation to trauma and trauma-informed care; that the experience of care will be one that ameliorates the impact of trauma.

Evaluation or research evidence





This review identified limited evidence of evaluations of the implementation of the Sanctuary Model. Following an initial pilot program across five residential units in Northeastern USA, an evaluation of outcomes of three residential centres implementing the Sanctuary Model for young people was undertaken and contrasted with the outcomes identified in 'standard' residential care services (Rivard et al., 2004; Rivard, Bloom, Abramovitz, Pasquale, Duncan, McCorkle & Gelman, 2003) A mixed-method, multi-level research design was implemented with promising results in respect of the Sanctuary Model implementation. Some variation in Sanctuary Model implementation was noted, however overall scoring of the extent to which a therapeutic environment had been implemented was seen to be higher on most scales for the Sanctuary Model Units. In addition, young people who were placed in Sanctuary Model residential units made more positive progress in the areas of reducing aggression, managing interpersonal conflict and problem solving than those young people in 'standard' care (Rivard et al., 2004; Rivard et al., 2003). These studies indicated the need for longer-term outcome research which included outcomes for young people over time. The Sanctuary Model has also been reported to be associated with a reduction in the seclusion of young people in care, the need to physically restrain them and the number of incidents of violence (Esaki, Hopson & Middelton, 2014).

More recently, an Australian agency, Pathways, in Queensland reported that the collection of 'quantitative and qualitative data, in the form of ongoing client, staff and carer surveys, provided evidence that the Sanctuary Model had made a positive impact upon the organisation's level of care provision, in addition to increased staff and carer provision' (Leigh-Smith & Toth, 2014, p. 232). The details of the research design were not identified.

3. The Model of Attachment Practice (MAP)

Overview

The Model of Attachment Practice is a model implemented in Northern Ireland, influenced by a Canadian model of treatment for young people, developed by the Maples Adolescent Treatment Centre in British Columbia. MAP is founded on attachment theory, which promotes relational interventions that can allow the child to develop safety, security and an opportunity to develop (Bowlby, 1979). This theory is complemented by an understanding of neurodevelopment theory and contemporary relational approaches which propose that nurturing relationships can impact positively on the development of neural circuits where trauma has been experienced (Perry, 2009).

Core Components of the Model

These theoretical concepts, along with carer strategies to use empathy and to be attuned to children's needs, result in a model of care that, rather than being highly prescriptive, is based on the following set of seven guiding principles:

1. **All behaviour has meaning.**
2. **Early and repeated experiences with primary caregivers set a foundation for our internal working models of relationships with self and others. These can change but it takes considerable time and repeated opportunities for unlearning and/or relearning**
3. **Biological legacies (our cognitive and physical capabilities, for example) are integral to our experience and contribute to our internal working models. Staff need to understand their impact for behaviour and children's limitations.**
4. **Internal working models develop in the context of relationships and experience. They are constantly under review on the basis of experience.**
5. **Interpersonal relationships are a process of continuous, reciprocal and unavoidable interplay between each person's internal working models and those of others.**
6. **We understand ourselves in relation to others. Our sense of self includes our sense of how others view and respond to us.**
7. **Enduring change in an individual's behaviour occurs only when there is change in their internal working models supported by change in the system. (MacDonald & Millen, 2012).**

Theory of Change

The theory of change is not explicitly documented; however, the underpinning theories and guiding principles imply that the theory of change is founded on developing carer's knowledge of the significance of attachment-based relational intervention, which includes a deep understanding of the needs of children who have experienced early trauma. On the basis of this knowledge, staff are more able to relate to children and young people in an empathetically attuned way. This in turn allows children to recover and to learn to experience positive and healthy relationships.

Evaluation or research evidence

There were no studies identified that have evaluated the effectiveness of the MAP program. The Maples Adolescent Treatment Centre has recently published a small qualitative study reviewing their Trauma-Informed Practice guidelines (Hunt, Moretti, Booth & Reyda, 2018). The study aimed to review the extent to which the practice was evidence-based and trauma informed, and utilised a 'participatory action model' to guide the research including in-depth interviews and observational tools for data collection. This small-scale study reported that children and young people and their families reported greater trauma awareness and an overall sense of safety and trust as a result of the Maples intervention. They also reported the capacity for choice, collaboration and connection within their treatment (Hunt et al., 2018).

4. The Social Pedagogy Model

Overview

The Social Pedagogy Model of care was introduced in Germany and Denmark late last century. The model is based on a European approach to child rearing which posits that the experiences of everyday life constitute opportunities for children to learn and integrate their knowledge as they develop their view of the world (Gharabaghi & Groskleg, 2010). Social Pedagogy was piloted in a number of sites in the United Kingdom from 2007 (Macdonald & Millen, 2012). More recently, it was implemented in Ontorio, Canada, with the development of the Ottawa River Academy: a model of residential treatment which is described as 'a living and learning program for youth in care that exemplifies the possibilities embedded in creative thought' (Gharabaghi & Groskleg, 2010, p. 98). This review did not find a single approach across the Nordic countries, who interestingly report very high use of residential care – up to 40% of all children in care in Denmark, for example (Jakobson, in Whittaker et al. eds, 2015). This data does not easily compare; however, in light of differing contexts, and counting arrangements which, in some Nordic countries, include children in care with a disability. Whilst there is not a single approach, social pedagogy has strongly influenced the development and delivery of therapeutic residential care, with a *'substantial group of children… placed in socio-pedagogical homes'* (Jakobson, in Whittaker et al. eds, 2015, p. 91).

Core Components of the Model

At the heart of this model is the facilitation of learning based on a multi-theoretical lens. Care is described as holistic, working with the whole child creatively to develop their potential as complex social beings (Macdonald & Millen, 2012). With a focus on learning, the model is said to create a balance between knowledge, skills and emotional wellbeing.

THE MODEL AS IMPLEMENTED IN NORTHERN IRELAND RESTS UPON NINE CORE PRINCIPLES AS FOLLOWS:

- **A focus on the child as a whole person and support for the child's overall development**
- **The pedagogue seeing themselves as a person in relationship with the child/young person**
- **Children and the pedagogue are viewed on the same level, not existing on separate hierarchical domains**
- **Pedagogues are encouraged constantly to reflect on their own practice and to apply both theoretical and self-knowledge to the demands of their work**
- **Pedagogues are practical: their training prepares them to share in activities of children's daily lives**
- **Children's peers and family are an important resource and pedagogues should foster and make use of this group**
- **Pedagogy builds on an appreciation of children's rights, which extend beyond policy or legal requirements**
- **There is an emphasis on teamwork and an understanding of the contribution of others in socialisation, for example, parents and members of the community**
- **The relationship between the pedagogue and the child is significant and inherent in this is the importance of communication and listening (Macdonald and Millen, 2012, p. 27).**

The implementation of these principles rests heavily on the knowledge and skills of the pedagogues or carers, and implies the need for an effective helping and learning relationship. It also implies well-trained staff who can respond to the individual learning needs of the child. The program is individualised based on the unique circumstances of the individual child or young person. In the Canadian context of implementation, social pedagogy has been described as replacing a psychotherapeutic orientation to care, which is premised on a belief that learning is 'the primary form of intervention and nurture' (Gharabaghi & Groskleg, 2010, p. 107). Consequently, the program is implemented via the individualised creation of learning opportunities at all stages of the lived experience in care.

Theory of Change

The implicit theory of change suggests that when skilled pedagogues develop trusting relationships with children, whom they view as complex social beings full of potential, the possibility for growth and development is facilitated.

Evaluation or research evidence

This review did not locate research outcomes or evaluation reports in respect to this model.

5. The ARC Model

Overview

The Attachment, Self-Regulation and Competency framework has been implemented in residential care facilities in parts of Northern Ireland. It was developed in Brooklyn, USA (Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Andres, Cohen & Blaustein, 2011) as a framework to guide clinical practice with children who have experienced early trauma. The authors suggest that 'culture is a critical consideration' (Ardvidson, et al., 2011, p. 39) and describe an ethno-culturally diverse cohort of children and proactive efforts to incorporate culturally relevant symbols, metaphors and activities into treatment.

Core Components of the Model

The three core domains of the ARC model are identified 'building blocks' which inform a series of 10 key strategies or targets for treatment. These are summarised as:

1. The Attachment Domain

This first domain has a focus on the child's caregivers and theorises that safe attachment relationships are at the foundation of all intervention. With this in mind, the following 'building blocks' of attachment are identified as:

- Caregiver management of affect
- Attunement
- Consistent response
- Routines and rituals/

2. The Self- Regulation Domain

This domain seeks to enable children and young people to develop coping skills that have been impaired as a result of exposure to complex trauma. Within this domain there are three building blocks:

- Affect identification
- Modulation
- Affect expression.

3. Competency

This third domain has a focus on skills that children and young people need to master to continue to develop in a healthy manner over time. This domain has two major building blocks:

- Building executive functions
- Self-development and identity.

A final ARC building block is identified as Trauma Experience Integration, which facilitates the integration of skills developed in each of the three previous domains to support children and young people in their ongoing development. This final building block is specifically tailored to each child, targeting post traumatic experiences which may be intrusive or unhelpful (Arvidson et al., 2011).

Theory of Change

A theory of change is not articulated; however, the Model documentation suggests that focusing on the child's caregiver system, including current carers and biological family, in a manner that promotes consistent and responsive, attuned relationships, will lead to greater capacity for children to self-regulate and learn.

Evaluation or research evidence

No evaluations of ARC implementation were identified in a residential or group care context. Early findings of the clinical implementation of the model, however, are reported by the Alaska Child Trauma Center, who along with other research partners tracked children's progress at baseline, at three-month intervals and at discharge from treatment, using instruments including the Child Behaviour Checklist (CBCL) and examining permanency outcomes (Arvidson et al., 2011). This small-scale study produced promising results, where 92% of children completing treatment were in a permanent placement post treatment, and overall CBCL scores were significantly lower than scores at baseline (Atkinson & Lamar, 2009, cited in Arvidson et al., 2011).

The ARC model implementation in the USA sits within the Complex Trauma Treatment Network (CTTN), which is currently undertaking large-scale evaluations of interventions and outcomes with young people and their carers (CTTN, 2018). Recent research indicates that implementation of ARC within a residential care setting for young people can lead to significant reductions in the use of physical restraint by staff and positive clinical outcomes for young people in care (Hodgdon, Kinniburgh, Gabowitz, Blaustein & Spinazzola, 2015).

6. Building Communities of Care (BCC)

Overview

This program is identified as a strengths-based, trauma-informed treatment model, developed in Massachusetts, USA. It is suggested that a unique feature of this model is that it combines an understanding of the impact of trauma on the developing child with the need to integrate a behaviour management system in residential care (Forrest, Gervaise, Lord, Sposato, Martin, Besserra & Spinazzola, 2018).

Core Components of the Model

The BCC model was developed as a strengths-based, family-involved model of care which seeks to create a 'restorative community' (Forrest et al., 2018, p. 270).

THE MODEL IS BASED ON THE FOLLOWING CORE CONSIDERATIONS:

- **The environment**
- **Clinical treatment**
- **Community engagement and behavioural interventions.**

Each of these considerations is seen through an ecological lens, including three cores systems: the individual, community and external systems. Each system is said to coordinate to enable the child to grow and internalise experiences of success.

The theoretical grounding for BCC draws heavily from the ARC model (outlined above), recognising that this trauma-informed model has shown promising research results for children and young people in care who have experienced complex trauma. BCC seeks to integrate the ARC design across each of the systems by offering 'strengths-based, individualised, milieu strategies and proactive and relationally driven behaviour management' (Forrest et al., 2018, p. 270). In this way the BCC model seeks to ensure integration of the therapeutic milieu, educational experiences, family relationships and clinical intervention. Central to the model implementation is the role of BCC carers who are charged with the task to 'collaboratively design, implement and maintain an environmental culture where instances of client dysregulation and difficulty become a rare occurrence' (Forrest et al., 2018, p. 272).

Theory of Change

There was no explicitly documented theory of change that this review identified. The implicit theory of change is that children and young people will experience well-coordinated, relationally based care which promotes attachment, self-regulation and skill development. The care experience should be combined with effective behaviour management which promotes emotional containment and regulation. Based on this system of care they will develop a healthy internal working model and grow in their capacity for learning and self - regulation.

Evaluation or research evidence

A program evaluation conducted following implementation of BCC in two residential care facilities did not involve a control group in the study design. The evaluation does, however, indicate promising results, including the reduction of restraint usage, which was maintained over time, the reduction of staff injury as a result of less frequent restraint usage, and the reduction of worker's compensation payout claims in the period following BCC commencement (Forrest et al., 2018). The authors highlight that these results are associated with the promotion of children's capacity for regulation and enhanced milieu safety.

7. Mercy Family Services Therapeutic Residential Care Program Australia

Overview

As a charitable organisation in the state of Queensland, Australia, Mercy Family Services are one of a number of agencies funded to provide residential care for children and young people. Their documented model of therapeutic care was piloted in four sites in South East Queensland and is based on an identified need to offer a trauma-informed therapeutic milieu model of practice which moved away from a focus on 'daily care provision and containment' (Wall, Redshaw & Edwards, 2013).

Core Components of the Model

The model is described as establishing a 'Community of Care' which is trauma sensitive and individualised to meet the needs of the young person. Attachment theory underpins an understanding of the significance of the carer–child relationship as the foundation of intervention.

NINE CORE INTERVENTION PRACTICES ARE OUTLINES AS FOLLOWS:

- **Assessment of needs**
- **Therapeutic milieu**
- **Residential carers as mediators of change**
- **Positive, caring practices**
- **Positive development**
- **Focused support**
- **Prevention**
- **Emergency management**
- **Corrective guidance and supervision**

(Wall, Redshaw & Edwards, 2013, p. 12).

Each of these nine core components of the model are said to form the foundation for practice. These components integrate with four areas of focus: 'General Wellbeing, Strengths and Interests, Identified Problems and Day-to-Day Behaviour Management' (Wall, Redshaw & Edwards, 2013, p. 11). In addition, advanced strategies documented include effective transition planning, staff training and activity programming; within what appears to be a strengths-based paradigm where carers are trained to 'catch them being good' (Wall, Redshaw & Edwards, 2013, p. 14).

Theory of Change

The framework is presented diagrammatically, depicting an implicit theory of change which has children and young people at the centre of the model, surrounded by the nine core components, and in turn surrounded by statements that they are 'needs-based, trauma sensitive, relationship-focused and attachment-focused. Finally, advanced strategies are listed, and the four areas of focus are placed at the outer rim of the diagram. The diagram and documentation suggest that when care has a trauma-informed treatment focus that incorporates the identified considerations, principles and practices, that children will participate in a healing experience and that the impact of trauma will be ameliorated.

Evaluation or research evidence

Whilst the program documentation has outlined a monitoring and evaluation framework, no papers indicating research or evaluation outcomes were identified in this review.

8. Bunjil Burri: An Aboriginal and Torres Strait Islander Model of Therapeutic Residential Care

Overview

The development of a therapeutic residential care program to meet the needs of Aboriginal and Torres Strait Islander children in Victoria, Australia has applied 'the key principles of a holistic approach to addressing the impact of complex trauma, where culture and community history need to be addressed to benefit the child and family' (Bamblett, Long, Frederico & Salamone, 2014). The program is said to incorporate some aspects of the mainstream models of therapeutic care in Victoria identified earlier, including therapeutic supports for children and young people and staff who are committed to and trained in trauma-informed practice (Bamblett et al., 2014).

Core Components of the Model

The core program elements are informed by a belief that, for Aboriginal children and young people, healing will take place through enabling their connection to culture.

CONSEQUENTLY, THE CORE COMPONENTS OF THE MODEL INCLUDE:

- **Comprehensive, culturally informed assessments and planning**
- **Social Networking Maps, used in conjunction with cultural networking tools**
- **Men and Women's Business which ensures that whilst in therapeutic residential care these issues are culturally appropriately managed**
- **Return to Country activities enabling Aboriginal children to visit and connect with their own community and Elders.**
- **Cultural Support Plans that assist children to understand their identity as an Aboriginal child**
- **Community and Cultural Participation where children are actively engaged and connected to cultural, community and sporting events. An example of these activities is documented as follows:**

> ***…The Aboriginal children from our Bunjil Burri (therapeutic residential care) participated in the unique experience in which they learnt about southeast Australian Aboriginal cultural practices of creating possum skin cloaks and helped work on and created two contemporary possum skin cloaks. (Bamblett et al., 2014, p. 209)…***

Theory of Change

The implicit theory of change is that, in the context of colonisation and dislocation from culture, healing will take place for Aboriginal children in therapeutic care where they are offered a holistic program that facilitates their connection to culture.

Evaluation or research evidence

Whilst a promising model in terms of its culturally safe design, this review did not identify any publications reporting on evaluation outcomes.

9. Positive Peer Culture (PPC)

Overview

Initially developed in the 1980s in the USA, Positive Peer Culture (PPC) is a model for developing positive youth cultures in residential care, and more widely, in organisations serving young people. It challenges the common view that group programs which bring together troubled youth are negative by design. The intent of PPC programs is to establish a positive and developmental peer culture where young people's needs to experience belonging, mastery, independence and generosity are met (Larson, 2010).

Core Components of the Model

Given that the PPC is premised on the power of peer influence and relationship, it seeks to establish a positive peer culture which promotes prosocial values and attitudes, as well as an empathetic perspective toward one's peers. Group meetings are a cornerstone of the model, where culture is developed and problems and dilemmas are seen as opportunities for learning and growth. The potential for the power of peers is emphasised rather than the power of adult authority.

FOUR TREATMENT COMPONENTS ARE IDENTIFIED WITHIN WHAT IS A MANUALISED PROGRAM AS FOLLOWS:

- **Building Group Responsibility**
- **The group meeting, where the importance of this as a vehicle for change is established. These meetings are the primary form of treatment and take place usually five times per week.**
- **Service learning, where young people are engaged in community service**
- **Teamwork primacy, which refers to the importance of staff teams working collaboratively around the child (James, 2011).**

Theory of Change

The theory of change is implicit and suggests that young people's attitudes, beliefs and behaviours can be powerfully transformed with the presence of a positive peer culture. When a positive peer culture is developed and maintained in a group care setting, young people are empowered to help each other to learn, develop and heal.

Evaluation or research evidence

The evidence for effectiveness is limited to a small number of studies where the program fidelity was compromised given that additional components were implemented. That said, one experimental study conducted in the early 1990s reported positive change in terms of prosocial behaviour and social skills (Leeman, 1993, cited in James, 2011). More recent studies have produced mixed results with an exploratory, qualitative study suggesting that for young people in the juvenile justice system the group process may not be helpful (Ryan, 2006, cited in James 2011).

10. Teaching Family Model

Overview

This longstanding model of residential treatment was initially implemented in the 1960s in a group home setting in Kansas, USA. The relatively well-known facility Boys Town uses an adaption of this model which has been widely disseminated across the USA, Canada and the Netherlands (James, 2011).

Core Components of the Model

THIS MANUALISED MODEL FEATURES THE FOLLOWING CORE ELEMENTS:

- **Careful recruitment of teaching parents (carers)**
- **Skill based training of treatment providers**
- **Carers seen as professional practitioners**
- **Twenty-four-hour consultation available to carers**
- **Proactive teaching interactions**
- **A peer leadership system**
- **Evaluation systems and annual reaccreditation**
- **An emphasis on a family-like living and learning environment.**

Theory of Change

There is no clearly specified theory of change, however, implicit to the model is an assumption that if young people are offered a family-like home, with highly skilled carers as teachers of life skills, they will develop a greater capacity for regulation and prosocial skills.

Evaluation or research evidence

This Model has been extensively researched and evaluated. Findings, in summary, indicate that the model has been associated with improvements in problem behaviours and a reduction in mental illness symptomology along with an increase in discharges to less restricted settings (Lazselere et al., 2004, as cited in James, 2011). One study, however, found that there was an increase in problem drinking post treatment program (Slot et al., 1992, cited in James, 2011).

11. The Lighthouse Foundation Therapeutic Model of Care

Overview

This Australian model of residential care describes itself as an attachment and trauma informed model for practice (Barton, Gonzalez & Tomlinson, 2012). The model offers longterm residential care for young people from 15 to 22 years of age who have experienced complex trauma. The operating model is one of neighbourhood houses each accommodating up to four young people and two professional carers.

Core Components of the Model

The Lighthouse foundation model aims to offer new experiences in attachment-based, nurturing relationships which will ameliorate the impact of trauma. Carers are said to be trained and supported by a professional team of staff who seek to promote consistency, stability and continuity of relationship in care. The model is not manualised, however is founded on the premise that having achieved a health care/young person attachment, trauma recovery can continue to take place across multiple family and social settings. There is an emphasis on building one-to-one relationships with carers who are empathetic and attuned to the young person's needs (Barton, Gonzalez & Tomlinson, 2012).

Theory of Change

The model of treatment is founded on an understanding that, for young people who have experienced trauma in their childhood, having access to new 'sites of wellbeing' in their lives (McLoughlin & Gonzalez, 2014) will result in healing and growth.

Evaluation or research evidence

There are accounts of success by young people who have been former Lighthouse Foundation residents (Barton, Gonzalez & Tomlinson, 2012), however, no evaluation or research documentation was identified by this review.

12. The Stop-Gap Model

Overview

The Stop-Gap Model was developed in the USA, and the implementation process documented (McCurdy & McIntyre, 2004) as a model that assumes that intensive therapeutic residential care can be used as a short-term strategy before children and young people progress to less intensive community-based options. The Model is designed for those children and young people who are seen to be in a 'downward spiral' of difficult and destructive behaviours, with an intensive short-term focus which is designed to prepare them and their families for success in the community following discharge (McCurdy & McIntyre, 2004).

Core Components of the Model

THIS BEHAVIOURALLY BASED INTERVENTION IS DESCRIBED AS ENCOMPASSING THREE LEVELS OF CARE AS FOLLOWS:

- **Intensive intervention, which aims to teach strategies and skills to enable young people to function without using problem behaviours,**
- **Environment based interventions, which include specific strategies that can be practised in the young person's external environment, and**
- **Discharge-related interventions, which have a clear focus on preparation for a return home to biological family or family-based carers.**

A strong emphasis is placed upon the implementation of a token economy which seeks to reward positive and prosocial behaviours as they are demonstrated across each of the levels of intervention. Intensive case management is a feature of the model which aims to facilitate learning transfer from the residential treatment setting to the wider environment, including school, community and post-discharge placement. This post-placement support is combined with Parent Management Training to assist carers post discharge to respond effectively to their child or young person.

Theory of Change

A theory of change has not been explicitly documented by the authors of the model. Implicitly, however, it is theorised that for young people who exhibit extremely problematic behaviours, that a three-tiered, behaviourally based suite of interventions, intensively delivered in the short term, will interrupt this negative trajectory. When this, in turn, is coupled with parent education and post-placement support, behavioural change can be maintained.

Evaluation or research evidence

Aspects of the model, including the implementation of token economies, have been in use over many decades (Liberman, 2000). One evaluation noted a reduction in the use of restraint practices following a one-year period of implementation (McCurdy & McIntyre, 2004).

13. Re-ED Model

Overview

This model of treatment, developed in the 1960s in the USA, was described as 'a project for the re-education of emotionally disturbed children. Re-ED was developed explicitly as a new way to meet a social need for which current institutional arrangements are conspicuously inadequate' (Hobbs, 1966). The model was later abbreviated to the name Re-ED, maintaining a focus on learning as the primary means of treatment and use of intensive group meetings, held frequently.

Core Components of the Model

Central to the approach is the use of the group as a vehicle for the treatment. The structure, purpose and goals of the group are negotiated based on the unique needs of the eight to ten children comprising the group, and meetings may take place several times each day. Group meetings may vary according to the particular focus, and may take the form of planning, problem solving or capacity building (James, 2011). The approach is said to be designed for short-term residential treatment of four to six months duration. It therefore has a focus on post residential care with a parent education component including 'homework' to be undertaken by young people with their parents or community-based carers (Hobbs, 1966).

Theory of Change

There is not an explicit theory of change. However, the teaching and group focus suggest a theory that young people can learn from each other where positive group interaction is intensively facilitated. This learning will translate into behavioural change which can be supported and maintained in a community setting.

Evaluation or research evidence

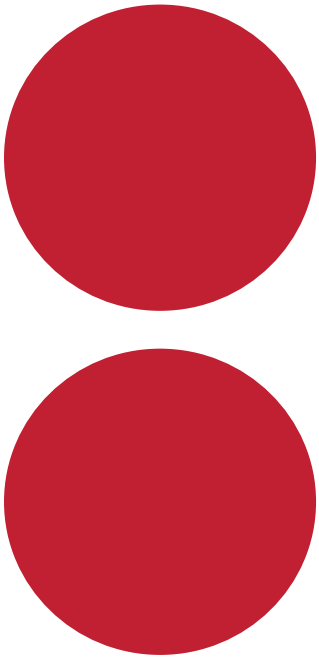
Whilst Re-ED is a model of treatment that has been implemented over the past 50 years, evaluation and research into its effectiveness, using comparison groups, is limited. A number of studies have been implemented using pre-test and post-test study involving following up of 111 young people at 6, 12, 18 and 24-month intervals (Hooper, Murphy, Devaney & Hultman, 2000). At discharge, nearly all students were rated as performing satisfactorily in at least one domain, whilst across 24 months this finding was reduced to 58% of the young people performing satisfactorily (Hooper et al., 2000).

14. Crotched Mountain Trauma-Informed Care (TIC)

Overview

A recently developed model of Trauma-Informed Care (TIC) has been implemented in New Hampshire, USA as a three-year program of implementation and evaluation (Barnett, Yackley & Licht, 2018). The model is described as informed by an understanding of the impact of complex trauma on children and young people and the potential of some residential care practices, including seclusions and restraint, to trigger trauma-related emotions which can exacerbate behaviour (Barnett et al., 2018).

Core Components of the Model



The initial three-year implementation process is outlined, indicating that the model itself has a focus on training and supporting residential care staff in aspects of trauma-informed practice via the implementation of seven two-hour training sessions followed by participation in reflective practice group sessions. Staff were incentivised to actively participate with the award of a salary increase if all sessions were completed and an exam passed at 80% or better. They were also required to demonstrate listening and participation skills during reflective group sessions and to complete a paper describing the way in which the program had changed practice in their workplace (Barnett et al., 2018). An onsite 'trauma expert' was responsible for the facilitation of reflective practice groups, and in turn had the support of external consultants. Internal supervisors and trainers were also recruited and trained over 100 staff participated in the training.

Theory of Change

A theory of change was not articulated, however it was hypothesised that at 'post intervention, the frequency or "dose" of staff participation in trauma-informed trainings and supervision groups would significant and positively relate to staff safety, trauma-informed skills and job satisfaction' (Barnett at al., 2018, p. 98). It was further hypothesised that staff turnover and critical incidents involving young people would decrease over time.

Evaluation or research evidence

The evidence for effectiveness is limited to impact for staff, who self-reported moderately high levels of 'safety, job satisfaction and trauma skills' (Barnett et al., 2018, p. 107) after one year of TIC implementation. Critical incidents were found to have decreased by 22% (although were reported to be decreasing anyway) whilst staff turnover actually increased. Limitations of this evaluation include the lack of a comparison group and a range of other initiatives being in place whilst the program was being implemented.

15. The Orchards Therapeutic Residential Care

Overview

Developed in the early 1990s in the United Kingdom, The Orchards Model of care is offered via seven group homes located in a community, each caring for three or four children and young people. The program is described as offering an integrated model of care for children who have experienced abuse or neglect and cannot live at home.

Core Components of the Model

THE THREE CORE COMPONENTS OF THE MODEL INCLUDE:

- **Therapeutic parenting in a home-like environment,**
- **The provision of formal play therapy sessions, and**
- **Life Story Work (Gallagher & Green, 2013).**

The therapeutic parenting offered seeks to provide a home-like environment and to repair attachment disruption with a consistent and nurturing environment. Each child participated in individualised play therapy sessions. Life Story Work was particularly detailed and offered by trained workers who collated information from a wide range of records and sources. This work forms the foundation for a deeper understanding about the child's history.

Theory of Change

The theory of change is not explicit. Central to The Orchards Model, however, is attachment theory's premise that where children have experienced attachment disruption, repair can take place with consistent, nurturing, professional parenting.

Evaluation or research evidence

One study was identified where former residents of the program, who were 16 years of age or older and had completed their education, were targeted. Efforts to find and recruit previous residents (n=117) resulted in 16 young people consenting to participate in an interview. The findings overall for this small cohort were promising, particularly in relation to their 'emotional and behavioural wellbeing, physical health, accommodation and absence of early parenthood and substance abuse' (Gallagher & Green, 2013, p. 44). A major limitation of this study is that it was not subject to an ethics committee review. A second limitation is that only 16 of the possible 117 former residents were interviewed.

16. The Spiral Model of Therapeutic Care

Overview

Spiral is described as an 'evidence-informed framework for therapeutic residential care (TRC)', and is a model of care developed in Queensland, Australia by a non-government organisation, Catalyst Child and Family Services. Recognising that an extremely high proportion of children in out-of-home care in Far North Queensland are Aboriginal and Torres Strait Islander, the model explicitly focuses on cultural safety, 'including the recruitment and support of Aboriginal and Torres Strait Islander staff.' The model involves the whole organisation, with effective leadership being an essential component (Downey, Jago & Poppi, 2015)

Core Components of the Model

The model is one which combines the trauma and attachment approach to recovery with a behaviour management approach, suggesting that it is possible to attend to the presenting issues of antisocial behaviours whilst attending to the underlying trauma that children and young people may have experienced. As a stage-based model, the initial stage of establishing safety is one which ensures that the child experiences safety in the home, school and community before moving onto the stage where they can work to make sense of past trauma and learn to self-regulate. A third and final stage seeks to enhance resilience and integration with one's networks. The authors of the Spiral Model indicate that workforce development is a priority, and includes personal and professional development as well as the provision of a suite of practical tools and strategies for working with young people in residential care (Downey, Jago & Poppi, 2015, p. 356).

Theory of Change

A theory of change is not explicitly articulated. The theoretical base and program design suggest that it is theorised based on trauma and attachment theories combined with behaviour management approaches that, if effectively implemented via a whole-of-organisation approach, children will successfully move through the three stages of healing and recovery.

Evaluation or research evidence

Only one publication was identified in relation to this recently developed model, which does not include evaluation or research findings.

17. Circle of Courage Model

This review identified limited models of care that were specifically developed to meet the needs of First Nations children and their families. The Circle of Courage is a model of practice based on traditional Native American knowledge and philosophy which suggests that 'there are four essential human needs that transcend time and place: belonging, mastery, independence and generosity' (Van Bockern & MacDonald, 2012, p. 13).

Overview

The model has been implemented in some schools in the USA and adapted for implementation in some care settings in Australia (ACF, 2015).

IT IDENTIFIES FOUR UNIVERSAL NEEDS OF ALL CHILDREN:

- **Belonging: opportunity to establish trusting connections,**
- **Mastery: opportunity to solve problems and meet goals,**
- **Independence: opportunity to build self-control and responsibility, and**
- **Generosity: opportunity to show respect and concern (Van Bockern & MacDonald, 2012).**

These principles are described as pathways to assist young people to identify and develop their strengths and for families to develop and maintain resilience (Garfat & van Bockern, 2010). The implications of the model are that children, young people and their families will thrive when these universal needs are met. The model offers hope and a strengths-based perspective within what is often seen as a problem saturated narrative.

Core Components of the Model

The core components of the model are founded on the four universal needs of children and implemented from a strengths-based perspective, promoting social skills and character development (Lee & Perales, 2008).

Theory of Change

Whilst not explicitly articulated, the theory of change implicitly assumes that where young people are related to holistically, and in a manner that proactively attends to their universal needs, that they will develop and thrive.

Evaluation or research evidence

Much of the documentation in relation to the Circle of Courage model is descriptive. One evaluation study was identified, however, that examined young people's experience of the Circle of Courage program over an eight-month period. The evaluation focused on the extent to which the four universal life needs of belonging, mastery, independence and generosity had been adopted by the young people and integrated into their daily lives. 29 young people completed an initial survey and 26 completed the follow up survey which were analysed in the context of daily behaviour reports for each young person. This small study suggested positive results in relation to the extent to which young people had experienced a sense of belonging and developed greater independence and mastery. There were mixed results in relation to the development of generosity, which, according to the program developers, had received less attention in program design (Lee & Perales, 2007).

18. Multifunctional Treatment in Residential and Community Settings: MultifunC

This Norwegian Residential Treatment Model was developed on the basis of a review of the existing research on residential treatment commissioned by the Norwegian Government in 2000 (Andreason, in Whittaker et al., 2015). The model is said to focus on both individual and environmental factors and includes planning for post placement and connection to community. As a manualised program it takes a whole-of-organisation approach, and all staff receive specific training in the requirements of the model. The program is offered as a phased or staged treatment program across three stages: intake, treatment and transfer. The theoretical influences are behavioural approaches, with a reward and levels system in place in a token economy, 'milieu therapy, which promotes an environment of structure and predictability, and a focus on family inclusion and involvement in the treatment, drawing on multi-systemic family therapy approaches (Andreason, in Whittaker et al., 2015).

Theory of Change

Whilst not explicitly articulated, the theory of change implicitly assumes that if the model is implemented with fidelity that antisocial and unhelpful behaviours will decline and connection to family and community will be strengthened.

Evaluation or research evidence

This review noted that implementation evaluations were underway, however, were not yet documented.

Therapeutic Practice Approaches in Group Care Settings

The review also identified four distinct practice approaches, as opposed to program models, that had been adapted and implemented in group care settings. These are summarised below.

1. Dyadic Developmental Psychotherapy in Residential Care

Overview

Dyadic Developmental Psychotherapy is an approach to treatment that was primarily designed to influence the parent–child relationship where children were seen to have experienced developmental trauma disorder (Becker-Weiderman, 2006; Hughes, 2014).

THIS APPROACH WAS DEVELOPED BY DAN HUGHES IN THE USA TO ADDRESS THE IMPACT OF TRAUMA, WITH A FOCUS IN SIX MAJOR AREAS OF INTERVENTION:

- **Safety**
- **Self-Regulation**
- **Self-Reflection**
- **Traumatic Experience Integration**
- **Relational Engagement**
- **Positive Affect Enhancement (Hughes, 2014).**

Core Components

One residential treatment program featuring DDP was identified in this review, the Chaddock residential model, in Illinois, Midwestern USA. Treatment is offered over a nine to eighteen month period where the promotion of staff–child attachment is said to be founded on a comprehensive staff development program (Clarke, 2011). Three developmental phases each promote healthy interrelatedness and 'presence' for the child within an overall theoretical model known as Playfulness, Acceptance, Curiosity and Empathy, or PACE (Clarke, 2011). DDP is fundamentally a relational form of treatment where carers work towards creating new, non-abusive relationships for children who have experienced trauma, enabling them to heal.

Theory of Change

Whilst a theory of change is not explicit, a series of hypotheses are documented as part of a research program as follows:

THAT DDP WOULD HAVE A POSITIVE EFFECT ON CHILDREN WITH REACTIVE ATTACHMENT DISORDER (RAD) IN THE FOLLOWING WAYS:

- **Symptoms of RAD will decrease**
- **Caregiver capacity to provide a secure base will increase**
- **Resolution of grief and loss issues associated with abuse and neglect**
- **Enhances social relationships**
- **Improved cause and effect thinking**
- **Reduced aggression**
- **More socially acceptable behaviour (Becker-Weidman, 2006).**

Evaluation or Research Evidence

DDP has been used to form the basis of the Chaddock residential model in Illinois, USA. The program website indicates that the 'Developmental Trauma and Attachment Program' has resulted in the successful fostering or adoptive care for three out of four children and young people who experience the residential program (Chaddock Residential Treatment, 2018). A more formalised program of evaluation, whilst small in scale, found that children and young people completing the residential program were found to have statistically significant positive changes in behaviour, mental health, and capacity to resolve conflict and socialise (Blackwell & McGill, 2008).

2. Dialectical Behaviour Therapy

Overview

Dialectical behaviour therapy (DBT) was initially developed in the 1990s in the USA as a treatment for women with borderline personality disorder who were suicidal. DBT has been adapted for several other populations including for adolescents, initially as a 12-week program (Miller, Rathus & Linehan, 2007). More recently, reflecting the average length of residential care stay for young people in the USA, it has been redeveloped as a 12-month program for adolescents in residential treatment (McCredie, Quinn & Covington, 2017).

Core Components

THIS MANUALISED PROGRAM CONTAINS FOUR CORE MODULES AS FOLLOWS:

- **Mindfulness**
- **Emotion Regulation**
- **Interpersonal Effectiveness**
- **Distress Tolerance (McCredie, Quinn & Covington, 2017).**

The five essential functions to be fulfilled include enhancing motivation to change, structuring the environment, developing capability, maintaining new behaviours and enhancing therapist motivation and capability. The four hierarchical stages of treatment are consistent with the severity of the presenting problem. Stage 1 has a focus on life threatening behaviours and those behaviours that impact on quality of life whilst promoting the capacity to engage in therapy. Stages 2 to 4 have a focus on many of the challenges faced by young people who have experienced posttraumatic stress, including emotional regulation, negative thinking and impulsiveness (McCredie, Quinn & Covington, 2017).

Theory of Change

DBT does not specify a theory of change, however documentation suggests an assumption that the identified problems that young people have arised from a combination of biological and environmental factors. It also assumes that young people may have attempted in many ways unsuccessfully to have their needs met. The DBT program is offered as a means of fulfilling five essential functions, which in turn will facilitate changed behaviour.

Evaluation or research evidence

DBT has been extensively researched in its application to adult populations and has been found to be effective across a range of populations and presentations (Miller, Wyman, Huppert, Glassman & Rathus, 2000). There is emerging evidence of effectiveness of this model of treatment for the adolescent population. A recently published study in Baltimore, USA tracked a small group of young people aged 12 to 18 years (n=48) who participated in a one-year residential treatment program using DBT-A, with promising results (McCredie, Quinn & Covington, 2017). Overall, clinical symptoms were reduced, and young people demonstrated an enhanced capacity to use the skills that they had learnt; particularly Distress Tolerance Skills, where there was significant growth (McCredie, Quinn & Covington, 2017, p. 84).

3. The Neuro sequential Model of Therapeutics (NMT)

Overview

This model was developed by Dr Bruce Perry of the Child Trauma Academy, Houston, Texas, USA, where it was used largely as an assessment tool with children who had experienced complex trauma (Perry, 2009). What followed was the development and implementation of a practitioner NMT certification program, where practitioners could learn to develop what is described as a developmentally sensitive, trauma-informed approach to practice (Hambrick, Brawner, Perry, Wang, Griffin & Strother, 2018). Most recently, the approach has been implemented within ten organisations from three countries (USA, Canada and Scotland) in residential care facilities (Hambrick et al., 2018).

Core Components

THE NMT CERTIFICATION INVOLVES TEACHING THREE COMPONENTS:

- **Capacity building and mastery of core concepts,**
- **An assessment process to determine the timing and the nature of developmental adversities and resilience-related factors, current functioning in multiple domains (e.g., sensory integration, self-regulation, relational, cognitive) and current relational milieu (i.e., connection to family, community, culture), and**
- **The selection and sequencing of specific educational, therapeutic and enrichment interventions. (Hambrick et al., 2018, p. 5).**

The core concepts of the approach are said to have evolved from clinical practice and research into neurobiology, traumatology and neuroscience. At the core of the approach is the deep understanding gained by practitioners of developmental trauma to better understand the 'emotional, social and behavioural sensitivity' that is common (Hambrick et al., 2018, p. 5). This shift in understanding enables carers to avoid interactions which will contribute to the child's dysregulation, and promotes capacity for interactions which regulate and avoid escalation for children. Certification is a manualised process where participants are exposed to print material, webinars and case study application of the material.

Theory of Change

The implicit theory of change is that based on enhanced knowledge of the impact of developmental trauma on the developing child, that carers will be better placed to construct a therapeutic milieu for children and to create space for children to heal. Children are viewed as having experiences which have impacted on their development, rather than having something 'wrong' with them. When this approach is consistently applied in a residential care setting, the use of physical restraint will decrease as will the number of critical incidents.

Evaluation or research evidence

The NMT model of therapeutics has recently published study results involving implementation in residential care settings (Hambrick et al., 2018, p. 6). Ten organisations from three countries agreed to implement the model and to share their de-identified data in relation to the use of physical restraint and the nature and number of critical incidents pre and post NMT implementation. In summary, whilst there were important differences in the use of restraint across services, and definitions of critical incident were varied, the results of the study were promising. Overall findings indicated 'significant reductions in restraints and critical incidents as a function of NMT implementation' (Hambrick et al., 2018, p. 11).

4. Multidimensional Family Therapy (MDFT)

Overview

MDFT was developed as a community-based intervention which has shown promising evidence in relation to its capacity to reduce the risk of children and young people entering the care system (Hoogeveen, Vogelvang & Rigter, 2017). It has recently been implemented in the Netherlands in residential care facilities.

Core Components of the Model

Based on structural and strategic approaches to family therapy, the approach seeks to enhance treatment motivation on the part of young people and their parents, to prevent young people from relapsing into past problem behaviour and to develop their capacity to manage conflict, reduce risk and to enhance life opportunities. The Dutch MDFT expertise centre designed an adapted version of the approach for implementation in residential care.

THE PROGRAM IS DELIVERED IN THREE STAGES:

1. **Parents and young people are encouraged to commit to the program.**
2. **The treatment plan is implemented, and includes understanding and recognising problem behaviour and parenting skills.**
3. **Concluding phase where what has been achieved is reviewed and future strategies for the young person and their family are agreed upon.**

Theory of Change

The theory of change is not articulated, however, it was hypothesised that across the treatment period that individual family and school related problems would decline for young people.

Evaluation or research evidence

The implementation was evaluated using a small, retrospective cohort study examining both outpatient and residential care implementation. A baseline was established as the initial commencement of the program, with the exit report constituting the point at which the success or otherwise of intervention could be measured. Outcome measures were constructed which measured change in problem behaviour and participant satisfaction with MDFT. Whilst a small and limited study, satisfaction rates with treatment were found to be high. In each outcome category – externalising behaviour, school functioning and family functioning – outcomes improved from baseline to exit. These findings are potentially promising.

Australian State Government Initiatives

A growing number of state and territory governments throughout Australia have begun to adopt therapeutic approaches to care. With the exception of Victoria, most of these initiatives do not yet appear to have published evaluation outcomes. Each of these initiatives are documented in the grey literature as frameworks or guidance, with the level of documentation ranging from a 'clearly articulated philosophy of care' (Australian Childhood Foundation 2015) to broad statements identifying their residential care model as therapeutic (Department for Health and Human Services Tasmania, 2018). Each state and territory with current documentation describing therapeutic care identify as trauma-informed. There is scope, however, for a range of practice approaches within most jurisdictions. A summary of the developments in Australian states and territories follows.

Victoria

Victorian Therapeutic Residential Care Programs

The state government Department of Health and Human Services in Victoria, Australia introduced Therapeutic Residential Care in 2007 across 12 pilot sites throughout the state. Following an independent evaluation of the initial implementation and outcomes for young people, the 'pilot' status of the model of care was removed and therapeutic residential care was integrated into the out-of-home care landscape in that state (Verso Consulting, 2011).

Core Components of the Model

THE PROGRAM DESIGN IDENTIFIES NINE CORE ELEMENTS AS FOLLOWS:

- **A 'therapeutic specialist' who is available to residential care staff individually and in formal reflective care team meetings. This position is held by a senior and experienced professional with specialist knowledge, adding value to assessments and therapeutic planning.**
- **Trained staff who are consistently rostered, promoting stability and predictability for young people.**
- **A relationship dynamic between staff and young people that reflects dynamic engagement and participation.**
- **A well-planned client mix is maintained in the Unit.**
- **Care team meetings that support collaborative and consistent practice.**
- **An environment that promotes reflective practice.**
- **A whole-of-organisation approach to the provision of therapeutic care, which has congruence.**
- **Provision of a home-like physical environment.**
- **Sound exit planning and the provision of post exit support.**

The independent program evaluation, conducted over a two-year period, which involved the collection of multiple sources of qualitative and quantitative data, utilised a range of tools to measure young people's progress. The evaluation formed the major conclusion that 'therapeutic residential care practice leads to better outcomes for children and young people than standard residential care practice' (Verso Consulting, 2011, p. 4). In summary, the key findings were that, when contrasted with the comparison (standard residential care) group, there were significant improvements in placement stability, family relationships, carer–child relationships and connection to the community. In addition, the evaluation found that there were significant improvements in young people's sense of self. Finally, it was noted that mental, emotional and physical health improved, and that risk-taking reduced. A key recommendation of the evaluation was to shift the focus of out-of-home care from one of 'care and accommodation' to one of a 'treatment' focus (Verso Consulting, 2011, p. 10).

New South Wales

New South Wales has recently implemented a program of intensive therapeutic care across the state as part of its wider permanency support program. Services are currently in transition to the new intensive therapeutic care arrangements from existing residential care (FACS, 2018).

In April 2016, FACS engaged a third-party expert, Verso Consulting (2016), to review the current residential care system in NSW and to design a therapeutic care model. Verso Consulting were selected due to their experience in the evaluation and subsequent development of the Victorian therapeutic care model.

The Development of NSW Intensive Therapeutic Care (ITC)

FACS accepted the direction of Verso's recommendations and then commenced the process of translating and operationalising the Verso reports through working groups and consultations, which led to the development of the ITC model.

Objectives of Intensive Therapeutic Care (ITC)

THE IDENTIFIED OBJECTIVES OF THE ITC ARE TO:

- **do more to protect and keep children and young people safe,**
- **address individual needs through the provision of therapeutic care with a strong focus on recovery from trauma,**
- **provide clear pathways to less intensive service types and permanency, and**
- **deliver evidence-informed services to improve client outcomes particularly around health and education.**

INTENSIVE THERAPEUTIC CARE (ITC) INCORPORATES:

- **an FACS Central Access Unit (CAU) – the entry point for all children referred to the FACS funded ITC service system,**
- **an Intensive Therapeutic Transitional Care (ITTC) service type,**
- **'Ten Essential Elements of Therapeutic Care' to guide service delivery across ITC,**
- **minimum staff qualifications and mandatory training,**
- **new staff positions inclusive of Therapeutic Specialists and Coordinators, and**
- **the establishment of the ITC intermediary organisation (FACS, 2018).**

Queensland

Queensland has released 'The Hope and Healing Framework for Residential Care', which is described as setting 'the foundation for caring and working with young people in residential care in a way that understands and responds to trauma and is therapeutic in approach' (Peak Care & Encompass, 2015). The framework identifies the theoretical foundation as a trauma-informed therapeutic framework that specifies five domains for therapeutic focus:

1. **the young person (their rights, their voice and their development),**
2. **the young person's connections (service is offered in context of community and culture),**
3. **the residential care environment (interactions with other young people and staff, connected and safe relationships, routines and rituals, purposeful programming and physical space),**
4. **the residential service provider (organisational procedures, staffing, rostering and collaboration with other services), and**
5. **working with the wider service system (health, education, disability and child protection) (Peak Care & Encompass, 2015).**

The framework offers guidance in relation to the principles underpinning therapeutic care whilst allowing scope for individual agency difference in operation (Peak Care & Encompass, 2015). This model is only now implemented.

Northern Territory

The Northern Territory Government commissioned the Australian Childhood Foundation (ACF) to develop a trauma-informed model of therapeutic residential care with specific reference to the needs of Aboriginal and Torres Strait Islander children. A continuum of care is outlined in the conceptual model and operating framework (ACF, 2015), which operates from emergency and after-hours care and offers a 'home like' environment, through to general residential care which provides a therapeutic home-like environment with skilled staff as carers, and finally, intensive residential care where 'the primary goal is to assess, deescalate and stabilise challenging behaviours in a therapeutic environment and transition the young people to an alternative arrangement'(ACF, 2015, p. 9).

Western Australia

The Western Australian Government released The Residential Care Conceptual in 2009, and updated it in 2012, along with an Operational Framework, describing a new model and core elements of therapeutic residential care. The Framework is informed by the principles of the Sanctuary Model developed by Sandra Bloom (2015) and is designed as a whole-oforganisation approach based on the understanding that 'traumatised children cannot heal within traumatising (or traumatised) organisations' (Department for Child Protection, WA, 2012). The framework outlines a plan to implement this approach with a focus on the principles espoused by Bloom (2005).

INCLUDING A:

- **Culture of nonviolence. Building safety skills.**
- **Culture of emotional intelligence. Helping to teach affect management skills.**
- **Culture of inquiry and social learning. Building cognitive skills.**
- **Culture of shared ownership. Helping to develop skills of self-control, self-discipline and an administration of healthy authority.**
- **Culture of open communication. Helping to overcome barriers to healthy communication, reduce acting out, improve self-protection and self-correcting skills, teach healthy boundaries.**
- **Culture of social responsibility. To rebuild social connections, establish healthy attachment relationships.**
- **Culture of growth and change. To restore hope, meaning, purpose and empower positive change (Department for Child Protection, WA, 2012, p.4).**

Tasmania

The Tasmanian Government website suggests that 'therapeutic interventions are provided to children and young people in care who have experienced trauma. The Australian Childhood Foundation provides this service and also provides training to carers and staff' (Department of Health and Human Services, Tasmania, 2018). This review did not identify documentation outlining a model of therapeutic care that had been adopted.

Australian Capital Territory (ACT)

In the ACT, a move toward therapeutic residential care is flagged in the government out-of-home care strategy discussion paper (DHHS 2015), where it is suggested that:

> ***…there needs to be a clear aim and therapeutic purpose to the placement. Residential care settings should include a focus on supporting young people to develop skills to move successfully to adulthood such as practical abilities including cleaning, cooking, paying bills and budgeting to more complex social abilities such as conflict resolution, managing stressful situations and becoming socially adept in a range of settings. Alternatively, residential care could be used to stabilise a young person before they are transitioned back to their birth parent or to a carer. ...Residential care settings that are flexible and therapeutic will be more able to meet the individual needs of young people and be able to facilitate the therapeutic inputs for the young person. These therapeutic inputs can then move with the young people rather than being connected to the service providing the placement. (DHHS 2015)…***

The new ACT Out of Home Care system is underpinned by the Step Up for Our Kids (SUFOK) 2015-2020 Strategy which clearly articulates a departure from the reactive and demand driven system of the past and "recasts the out of home care system as a therapeutic, trauma-informed system of care" (SUFOK, p. 5)

> ***…The Out of Home Care Strategy is emphatically child-focused and based on an understanding that all children and young people who enter care have suffered trauma as a consequence of both the circumstances that led them to enter care and the loss of familiar relationships and environments. The strategy seeks to ensure all services to children and young people in care provide positive, safe, healing relationships and practices that are informed by a sound understanding of trauma, attachment and child development (SUFOK, p.6)….***

Practice Approaches, Models or Frameworks?

This review scoped a total of eighteen distinct models of therapeutic group care and four distinct approaches to practice that have been implemented in group care settings. In addition, it was noted that states and territories in Australia now support the implementation of a therapeutic approach to residential or group care. Naming conventions for models, approaches or practices varied widely, with some 'models' using these terms interchangeably (Bloom, 2005) to describe their work, whilst others implementing what appears to be a practice approach may refer to their work as a 'model' (Hambrick et al., 2018). We agree with MacDonald and Millen (2012), that whilst language describing the work is important, attempting to conceptualise approaches versus frameworks versus models may not be productive. We have elected to refer to each of the models identified as 'approaches' to therapeutic care.

What follows is an analysis of the 22 approaches to therapeutic care. We begin with an examination of the sources of knowledge upon which the approaches are based, before presenting an overview of the evidence for effectiveness and concluding with a presentation of nine promising approaches.

'Sources of Knowledge' Underpinning the Approaches

Here we discuss the approaches in terms of the 'sources of professional knowledge' that they have explicitly drawn upon to design, implement and review their approach.

SOURCES OF PROFESSIONAL KNOWLEDGE ARE DEFINED HERE AS INCLUDING THE FOLLOWING ELEMENTS:

- **Empirical knowledge (drawing upon a range of study designs and methods)**
- **Theoretical knowledge**
- **Cultural knowledge, and**
- **Self-knowledge and practice wisdom (Thompson & West, 2013)**

It is suggested here that of these 'sources of knowledge' contribute to professional practice in therapeutic care and that this model of professional knowledge allows for a holistic analysis of approaches to be undertaken, which is inclusive of context and culture. What follows is an overview of the first three sources: research, theory and culture, in the context of the available documentation. Information regarding the way in which practice wisdom contributes to therapeutic residential care is of interest; however, the literature reviewed was silent in this area.

Research evidence (Empirical Knowledge)

Earlier we presented each approach with commentary on evaluation or research evidence post implementation. This involved an examination of the available documentation that evaluated the outcomes of the approach. What follows is an examination of the documentation for evidence of the inclusion of research in their program design. The majority of the approaches indicated that they were informed by research in their design, however few of these made the sources of the research explicit in the documentation available to this review. Notable exceptions were CARE (Holden et al., 2010), Sanctuary (Bloom, 2005) and NMT (Hambrick et al., 2018), who each refer to their own program of research as instrumental in the development of their approach.

Theoretical knowledge

Three broad theoretical concepts influenced the design of the 22 approaches to therapeutic care that this review identified: behaviour modification, social learning, and approaches based on neuroscience, trauma and attachment. **Behaviour modification** was implicitly identified as the prevailing theoretical concept underpinning the Stop-Gap approach, which describes a system of token economy and levels of intervention (McCurdy & McIntyre, 2004). This theoretical approach was designed more than four decades ago, influenced by the behavioural psychologist B.F. Skinner, who proposed that for adult inpatients of psychiatric facilities acceptable behaviour could be 'learned' by using prompts and modifiers and 'rewards' in the token economy. Used in group care settings for children and young people, the theory assumes that token economy techniques can address presenting behavioural problems and lead to lasting change. Applied to group care settings, use of token economy systems are contested as potentially harmful, with a suggestion that they can be 'provocative and punitive – thus inadvertently increasing children's high risk behaviours (Mohr, Martin, Olson, Pimariega & Branca, 2009).

Social learning theory was explicitly identified in the Social Pedagogy approach as the theoretical foundation and is implicit in the design of the Re-ED approach and approaches used in Nordic countries. Social leaning theory posits that the everyday lived experience of children and young people offer opportunities to learn and to integrate new knowledge into their world view and capabilities (Gharabaghi & Groskleg, 2010). This theory takes a European approach to learning as holistic and inclusive of all aspects of social and emotional development. The theory does not seek to address any underlying concerns that children may bring to group care, including experiences of early adversity and complex trauma.

Trauma-informed approaches dominated the theoretical landscape in this review, with 21 of the remaining 22 approaches articulating the development of their therapeutic approach as founded on or influenced by trauma theory. This dominant theoretical approach does appear to reflect and acceptance of the proposition put forward by the trauma-informed movement that 'it is not what is wrong with you, it is what happened to you' that is important to the approach to treatment. This unifying feature of the theory is said to shift the response from one of control and coercion to caring and reducing the need for intrusive and potentially retraumatising practices such as seclusion and restraint (Hambrick et al., 2018). One implication of this theoretical orientation is the important role of the therapeutic milieu and relationships within the group care setting, enabling healing and recovery to take place. Trauma-informed approaches are not, however, a homogenous group, with approaches to care variously emphasising the role of attachment (Donald & Millen, 2012) versus the significance of a whole-of-organisation approach to healing (Bloom & Farragher, 2011) versus an individualised treatment plan based on theories of traumatology, neurobiology and cognitive behavioural theories (Hambrick et al., 2018). Further research is required to understand the implications of this difference in emphasis and orientation in frontline practice.

Cultural Knowledge

Culture has been defined as the integrated pattern of human behaviour that includes thoughts, behaviours, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group (SNAICC, 2015). Cultural knowledge, in an Australian context recognises that the experiences of trauma and loss for Aboriginal and Torres Strait Islander Australians, present since European invasion, are a direct outcome to the disruption to cultural wellbeing and continue to have intergenerational effects. Cultural knowledge includes appreciating historical context and developing an understanding of ways of knowing that are unique to Aboriginal and Torres Strait Islander peoples. This implies an appreciation of culturally specific models of healing that are being developed in Aboriginal and Torres Strait Islander communities.

In light of the longstanding concerns about the over-representation of Aboriginal and Torres Strait Islander children in care, the limited documented evidence of cultural approaches to care is concerning. This review identified only four approaches that explicitly documented the use of cultural knowledge. The Spiral Model is an Australian approached developed in an era where there is a majority of Aboriginal and Torres Strait Islander children in care and where efforts to respond with cultural sensitivity are documented. The Bunjil Burri approach is an Aboriginal and Torres Strait Islander Australian approach to therapeutic care, developed to meet the needs of Koori (Victorian) Aboriginal children. The Circle of Courage approach is said to be based on Indigenous American knowledge and philosophy (Van Bocken & MacDonald, 2012). The ARC model has been implemented with an ethnoculturally diverse group of children including Native American and Alaskan children using cultural metaphors, symbols and activities (Ardvidson et al., 2011).

What Evidence for Effectiveness of Therapeutic Approaches to Care did we find?

Consistent with other recent international reviews (McLean, 2018; MacDonald & Millen, 2012), this review found limited evidence that unequivocally demonstrates the effectiveness of approaches to the provision of therapeutic care. Whilst a number of approaches describe themselves as ‘evidence-informed’ (see for example, Forrest et al., 2018), what they refer to is the incorporation of some empirical practices into the design of their approach. An example of an ‘approach to an evidence hierarchy’, which endeavors to address the multidimensional nature of evidence, is outlined below in Figure 1. The aim of this hierarchy, developed for a heath care context, was to help individuals determine what valid evidence existed within very narrow parameters.

Figure 1. Hierarchy of evidence: ranking of research evidence evaluating health care interventions (Evans, 2013)

	EFFECTIVENESS	APPROPRIATENESS	FEASIBILITY
Excellent	• Systematic Reviews • Multi-Centre Studies	• Systematic Reviews • Multi-Centre Studies	• Systematic Reviews • Multi-Centre Studies
Good	• Randomised controlled studies • Observational studies	• Randomised controlled studies • Observational studies • Interpretive Studies	• Randomised controlled studies • Observational studies • Interpretive Studies
Fair	• Uncontrolled trials with dramatic results • Before and after studies • Non-randomised controlled trials	• Descriptive studies • Focus Groups	• Descriptive Studies • Action Research • Before and After studies • Focus Groups
Poor	• Descriptive Studies • Case studies • Expert opinion • Studies of poor methodological quality	• Case studies • Expert opinion • Studies of poor methodological quality	• Case studies • Studies of poor methodological quality

Based on this hierarchy, the approaches to therapeutic residential care identified by this review do not fare well, with the majority of them falling within the bottom of the hierarchy at the 'poor' or 'fair' level. We suggest that 'hierarchies of evidence', which do not value post test study designs or designs that involve non-randomized control groups, may not demonstrate the actual value of therapeutic approaches to group care. Used inflexibly, hierarchies of evidence may underestimate the value of 'evidence' obtained in different cultural, socio-political and historical contexts.

Hierarchies of evidence may fail to appreciate the value of the rich narrative that local communities and service users, including children and young people in residential care, may offer. Whilst well-designed, rigorous programs of research in relation to client outcomes are of critical importance, we propose a more flexible approach to an evidence hierarchy. We now consider the contribution of implementation science.

The contribution of implementation science

Implementation science is commonly defined as:

> ***…The study of methods and strategies to promote the uptake of interventions that have proven effective into routine practice, with the aim of improving population health. Implementation science therefore examines what works, for whom and under what circumstances, and how interventions can be adapted and scaled up in ways that are accessible and equitable. (Global Alliance for Chronic Disease, 2018, p. 1)…***

Importantly in the context of the implementation and evaluation of therapeutic care approaches, implementation science seeks to address the gap in knowledge between interventions that research has indicated to be effective and their translation into practice. In doing so, it is suggested that implementation science may be better able to account for the complexities of practice, environments and systems within which interventions such as therapeutic care are implemented, since other approaches often fail to address these (GACD, 2018).

Drawing upon implementation science, a conceptual map of 'evidence-informed implementation' has recently been developed in and for the Australian context (Atkins & Frederico, 2017). This model of program implementation recognises the need to relate organisational performance, innovation and knowledge translation and implementation science within an Australian cultural context. This research was informed by structuration theory, which assumed that the experience of frontline practitioners would influence and be influenced by the implementation process. The 'map' of evidence-informed implementation that is proposed by these authors includes five key factors emerging as drivers. These are conceptualised as operating in concert and are summarised as including five key concepts.

THEY ARE AS FOLLOWS:

1. **Clear and transparent implementation planning and communication – knowing how implementation will happen and who responsible.**
2. **Frontline managers who are committed to innovation and effectively disseminating key information, offering professional support and clarifying expectations.**
3. **A reflective organisational culture – set by team leaders who promote the value of reflection as a practice approach.**
4. **Perceived fit between what would achieve improved client outcomes and the theoretical and research base informing the newly implemented program.**
5. **Workers who are open to change and innovation. A motivated and open attitude is a key attribute in achieving successful implementation (Atkins & Frederico, 2017).**

This evidence-informed model of implementation would seem to be a good fit for an analysis of the effectiveness of approaches to therapeutic group care. Drawing from these five criteria, notwithstanding the gaps in available documentation in relation to some of the approaches, it would appear that those approaches adopting a whole-of-organisational approach, implementing practices with a clear, trauma-informed theoretical and research base appear to be the most promising.

Thirteen Promising Approaches

Drawing upon a holistic approach to knowledge, the following criteria were used to determine which of the approaches to therapeutic care could be assessed to be 'promising':

- **Documentation showing broad alignment with the five key implementation concepts, identified previously (Atkins & Frederico, 2017).**
- **Documented promising evaluation outcomes.**
- **Program development inclusive of cultural knowledge and cultural considerations.**

Based on available, published information, thirteen approaches were found by this review to be promising. For eleven of the thirteen there was some evidence of positive evaluation or research outcome, as well as indications of alignment with the five key implementation concepts identified earlier (Atkins & Frederico, 2017). Two of these approaches also incorporate cultural considerations (Ardvidson et al., 2011; Lee & Perales, 2005). In the remaining two examples of a promising approach, a culturally specific model of therapeutic care is documented as a constructive alignment to the implementation concepts and careful consideration of cultural approaches to healing (Bamblett et al., 2014; Downey, Jago & Poppi, 2015).

Each of the approaches are summarised below in terms of implementation and evaluation:

1. **Bunjil Burri: An Aboriginal and Torres Strait Islander Australian Model of Therapeutic Care.** Whilst this review did not identify published evaluation outcomes in relation to this model, what it did identify were considered models of planning and consultation with the local Aboriginal and Torres Strait Islander community with a view to developing a culturally specific model of therapeutic care. The core components of the approach are documented and integrated knowledge that the essence of healing for Aboriginal and Torres Strait Islander children is founded on cultural safety and comprehensive, culturally informed assessments and planning. All frontline staff and managers are described as committed to and trained in culturally safe, trauma-informed practice (Bamblett et al., 2014).
2. **The CARE** approach involves all levels within the organisation, drawing on trauma and attachment theory with a clearly articulated theory of change. Planning and implementation are well documented and transparent. Leadership commitment is required and supported, and reflective practice valued. Multi-site studies have been completed and have involved non-randomised control groups. Findings in studies located in the USA indicated significant declines for three types of problem behaviour (Holden & Izzo, 2016).
3. **The Sanctuary Model** is also a whole-of-agency approach with a commitment to democratic behaviour required by all staff and managers. Opportunities for and an expectation of reflective practice are built into the approach as is a clear rationale and theoretical base, as opposed to an identified theory change. Most studies identified were conducted in the USA and were of mixed-method design, with results demonstrating a reduction in the use of restraint and seclusion practices along with positive progress made by young people in problem solving and resolving conflict (Rivard et al., 2004).
4. **The Attachment, Self-Regulation and Competency (ARC)** approach has a clear attachment-focused theoretical basis and extensive program documentation outlining targets for treatment. It seeks to closely 'fit' the individual child's needs and includes a focus on the child's family and community. The authors suggest that 'culture is a critical consideration' (Ardvidson et al., 2011, p. 39), and describe an ethno-culturally diverse cohort of children and proactive efforts to incorporate culturally relevant symbols, metaphors and activities into treatment. One small-scale study showed promising results in terms of permanency outcomes post treatment (Ardvidson et al., 2011).

5. **Building Communities of Care (BCC)** is an approach that is holistic and ecological in design with a clear theoretical foundation. Consistency of the therapeutic experience across multiple domains is a core objective. Evaluations indicate reductions in the need to use restraint and a reduction in staff injury (Forest et al., 2018).

6. **Positive Peer Culture (PCC).** This approach draws on the power of the group as a vehicle for change, and in doing so involves the whole organisation. A well-documented plan is transparent and available to all staff, who are required to commit to the group work process. Recent studies show promising outcomes for young people in group care in terms of increased prosocial behaviours, however are mixed in relation to juvenile justice outcomes, where group processes are not always found to be positive (Ryan, 2006 cited in James 2011).

7. **Dyadic Developmental Psychotherapy** was implemented as an approach to care in Illinois, USA, where it was implemented via a detailed staff training program with an explicit theoretical basis and a requirement that all staff adopt the PACE approach to working with young people (Clarke, 2011). A small-scale program evaluation found that on completion of the program children had statically significant, positive changes in behaviour, mental health, and capacity to resolve conflict and socialise (Blackwell & McGill, 2008).

8. **Dialectical Behaviour Therapy** has been adapted for use in group care as part of a 12-month residential care program in the USA (McCredie, Quinn & Covington, 2017). The approach is manualised and has extensively documented the four core modules offered over four stages of treatment. Extensively researched with reference to adult populations, there is now emerging evidence in respect to adolescent group care, indicating reduced clinical symptoms and a greater capacity to use learnt skills for young people who completed the program (Quinn & Covington, 2017).

9. **The Neuro sequential Model of Therapeutics (NMT)** is an approach to the assessment and treatment of children that has been adapted to group care settings in the USA and the United Kingdom (Hambrick et al., 2018). Training in the approach is certified, thoroughly planned, documented and based on emerging research and theory in neurobiology, traumatology and neuroscience. A small, retrospective study indicated promising findings in relation to problem behaviour reduction, school functioning and family functioning (Hambrick et al 2018).

10. **Stop-Gap** is a short-term therapeutic approach intensively delivered within the care setting and across the wider environment in preparation for discharge. The token economy behavioural modification approach seeks to reward positive behaviours across three tiers of intervention which clearly document a learning program for young people. One evaluation noted a reduction in the use of restraint practices following a one-year period of implementation (McCurdy & McIntyre, 2004).

11. **Teaching Family Model** is an approach which has been widely implemented across the USA, Canada and the Netherlands, and as a manualised model has clear planning and implementation documentation which includes annual reaccreditation processes and training programs for professional carers. Evaluations over time are promising and indicate reduction in problem behaviours and mental illness symptomology (Lazselere et al., 2004, cited in James 2011).

12. **The Spiral Model** is described as an Australian, evidence-informed framework for therapeutic residential care which recognises that a high proportion of children placed in care are Aboriginal and Torres Strait Islander. The model focuses on cultural safety, involves a whole-of-organisation approach and explicitly seeks to recruit and support Aboriginal and Torres Strait Islander staff (Downey, Jago & Poppi, 2015). Only one publication was identified in relation to this recently developed model which outlined the development and implementation, however it does not include evaluation or research findings.

13. **The Circle of Courage** is based on traditional Native American beliefs and philosophy. In a residential care setting it promotes a sense of belonging, the development of mastery independence and a sense of generosity for First Nations children and young people (Lee & Perales, 2005). It is described as a model for promoting resiliency and empowerment that 'originated from Native American culture' (Lee & Perales, 2005, p. 2). One study involving 29 youths in a mixed-method assessment – of the extent to which young people in residential care programs had integrated the four key components of the Circle of Courage components – was conducted over an eight-month period, yielding positive results.

Conclusion

This report presents a systematic scoping literature review to examine and understand the nature and scope of existing research on therapeutic group care across international and English-speaking jurisdictions. It also sought to scope children and young people's experiences of trauma, and the implications for a therapeutic response. The review aimed to address the question, 'What is the evidence base for therapeutic care?'

In responding to the question, the review identified four distinct domains of enquiry. Eight databases were systematically searched. A breadth and depth of material supporting an orientation to therapeutic care that is trauma-informed, as opposed to primarily behaviourally or learning-focused, was found. That said, there are a range of approaches to practice that each identify as trauma-informed; that is, they are not homogenous.

The overarching response to the question 'What is the evidence base for therapeutic care?' is that it is emerging. In our review of documented approaches, in terms of their implementation, evaluation and research outcomes, we found a marked lack of 'evidence' as it is traditionally defined in terms of health-oriented research hierarchies. The few randomised, controlled research designs and longitudinal outcome studies is likely to reflect the complexity of the 'real world' of practice with children who have experienced trauma. It is within this context that this review reports on thirteen 'promising approaches'. Ten of the thirteen were international approaches and the remaining three Australian.

What Were the Common Elements of the 'Promising Approaches'?

Eleven of the thirteen were international approaches and the remaining two Australian. Almost all of the promising approaches identified a trauma-informed approach, had clarity of implementation documentation and strategy and evaluation outcomes. The clarity of documentation most often went beyond a description of the core elements of the approach. It typically included a comprehensive theoretical and research evidence base, which had formed the basis of the construction of the approach. The 'elements' of the approach then appeared to be constructively aligned with a sound theoretical and empirical foundation. Common to the majority of the approaches was the use of trauma theory, trained staff and the establishment of a 'therapeutic milieu' as the foundation of care, supported by a congruent, whole-of-organisation commitment.

A critical consideration, documented by just three of the approaches to therapeutic care, is the need to incorporate cultural considerations into the design and delivery of therapeutic care for First Nations children globally. In Australia, for Aboriginal and Torres Strait Islander children, this must include an understanding of intergenerational trauma and the central place of cultural identity and connectedness in the lives of families and communities.

What Further Research is Needed?

Further research is needed to inform policy and program development in this important arena.

PRIORITY RESEARCH AREAS INCLUDE:

- **Understanding specifically configurations of how different experiences of trauma lead to different consequences for young people's development and functioning and how to best attend to them.**
- **Developing, implementing and evaluating cultural models of therapeutic care.**
- **Designing longitudinal studies which can track pathways into and out of therapeutic care.**
- **Workforce development approaches which enhance staff capacity to work effectively and therapeutically in in consistent environments that maximise the potential of the young people in care.**

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